Within corporate limits

Louis Berger

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

518 12000

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 643 Henderson Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 643 Henderson Ave (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mr John Nicholas Ackerman

3.(b) Social Security Number 214-05-4755

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married.

6.(b) Name of husband or wife: Catherine Adam

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): Dec 22, 1876

8. AGE: Years 72 | Months 0 | Days 0 | If less than one day ... hrs. ... min.

9. Birthplace (Town, county, and state): Cumberland, Allegany Co, Md.

10. Usual occupation: Brewery Worker

11. Industry or business: Cumberland Brewing Co.

MOTHER FATHER

12. Name: Joseph Ackermann

13. Birthplace: Germany

14. Maiden name: Barbara Reichert

15. Birthplace: Germany

16. Informant: Edward Ackerman

Address: 812 Shawnee Ave – Cumb Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 24, 1948. (month) (day) (year)

Cemetery or crematory: Sts. Peter & Paul's Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Dec. 24 1948 (Date rec'd by registrar) W. A. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 22 1948 at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 12 1948 to Dec. 22 1948 and that I last saw him alive on Dec. 17 1948

Immediate cause of death	DURATION
metastatic carcinoma of both lungs	2 months
Due to: carcinoma of the prostate	6 months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Minor M.D. M.D. or other

Address: 12-24-48 Date signed: 5 E. Green St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Within corporate limits

12001

51b

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

1. PLACE OF DEATH:

County: allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: 121 Race St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.: 121 Race St (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME John Clarence Baldwin

3.(b) Social Security Number 705-05-4995

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Hema Proudfoot

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Sept 2, 1876

8. AGE: Years 72 Months 3 Days 26 If less than one day ....hrs. ....min.

9. Birthplace: Beryl Mineral Co. W. Va (Town, county, and state)

10. Usual occupation: Retired Craneman

11. Industry or business: B & O. Railroad.

FATHER 12. Name: Wilbert W. Baldwin

13. Birthplace: Moozefield W. Va

MOTHER 14. Maiden name: Elizabeth

15. Birthplace: St Louis Mo.

16. Informant: Mrs J. C. Baldwin

Address: 121 Race St - Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 30, 1948 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland Md.

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Dec. 29 1948 (Date rec'd by registrar) W. K. Frank M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 28 1948 at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1941 to Dec. 28, 1948 and that I last saw him alive on Dec. 28, 1948

	DURATION
Immediate cause of death: Carcinoma Prostate	7 yrs.
c Carcinomatosis	2 mon.
Due to: Myocarditis	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clay R. Furrer M. D. or other

Address: Cumberland Date signed: 12/28/48

Within corporate limits

12602

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACESED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 128 Greene St.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME Infant Barham

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 4 1948

8. AGE: Years — Months — Days — If less than one day: 1 hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Chas E Barham
13. Birthplace: Md

MOTHER 14. Maiden name: Adeline Inc Kenzie
15. Birthplace: Md.

16. Informant: Chas E Barham
Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 7 48 (month) (day) (year)

Cemetery or crematory: St Patricks Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc
Address: Cumberland

19. Dec. 7 1948 (Date rec'd by registrar) W. R. Beatty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 4 1948, at 7:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 4 1948 to Dec. 4 1948 and that I last saw h alive on Dec. 4 1948

Immediate cause of death	DURATION
Prematurity (20 wks gestation)	1 hr
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Arthur F. Jones M.D.
M. D. or other

Address: 1105 S. Centre St. Date signed: 12-6-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

119a

12003

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 mo - 25 da

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 711 Bedford St.
(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Charles Thomas Batt

3.(b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Aug 16 1948

8. AGE: Years | Months: 3 | Days: 25 | If less than one day ... hrs. ... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER
12. Name: Charles A. Batt
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Catherine Kline
15. Birthplace: W. Va.

16. Informant: Mrs Chas A Batt

Address: Cumberland.

17. Burial (Burial, cremation, or removal Which?) Date thereof: Dec 13 48 (month) (day) (year)

Cemetery or crematory: St Peter & Paul's Cem

Location: Cumberland

18. Funeral director: Lomo Stein Inc.

Address: Cumberland.

19. Dec 13, 1948 (Date rec'd by registrar) W. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 11 1948 at 4 50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 9 1948 to Dec. 11 1948 and that I last saw him alive on Dec. 10 1948

Immediate cause of death: Cutaneous Colitis — DURATION

Due to:

Due to:

Other conditions: Malnutrition

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Felix Bezdos M.D. (M. D. or other)

Address: La Vale, Md. Date signed: 12/12

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Dr Bunge

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

157 m 120114

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 da.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 4 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 709 Seffert Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Joseph Harvey Bedinger Jr

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec 6 1948

8. AGE: Years | Months | Days: 4 | If less than one day: hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER

12. Name: Joseph H. Bedinger.

13. Birthplace: Md

MOTHER

14. Maiden name: Mary Sue Knisley

15. Birthplace: Bedford Pa

16. Informant: Joseph H. Bedinger

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 11 48. (month) (day) (year)

Cemetery or crematory: Hillcrest Elm-

Location: Cumberland

18. Funeral director: Louis Stein Inc.

Address: Cumberland Md

19. Dec. 11 1948 W. R. Treaty, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 10 1948 at 12:12 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6 Dec 1948 to 10 Dec 1948 and that I last saw h. alive on 10 Dec 1948

Immediate cause of death	DURATION
Prematurity & Respiratory failure.	
Due to: Premature labor	
Due to:	
Other conditions: Complete Atresia Rectum & lower 2/3 Sigmoid. (Include pregnancy within 3 months of death)	

Major findings of operations: Congenital atresia lower 2/3 sigmoid & rectum Date of op. 8 Dec 48.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Fuller B. Mutsworth M. D. or other

Address: 112 Bedford St. Date signed: 10 Dec 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits DR. JACOBSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

51 b

12005

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

I

VS A15 9-45-1

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 DAY

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: Near CUMBERLAND, Rural (If outside city or town limits, write RURAL and give nearest town)

Street No.: ROUTE #1, LA VALE (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: MR. BRUCE BLOCHER

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: MILDRED ELLIOTT

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): AUGUST 10, 1869

8. AGE: Years 79 | Months 4 | Days 4 | If less than one day: hrs. min.

9. Birthplace: MARYLAND (Town, county, and state)

10. Usual occupation: RETIRED Farmer

11. Industry or business:

FATHER — 12. Name: HENRY BLOCHER; 13. Birthplace: ~~INDIANA~~ Maryland

MOTHER — 14. Maiden name: SALINA CHANEY; 15. Birthplace: MARYLAND

16. Informant: MEMORIAL HOSPITAL

Address: MEMORIAL AVENUE

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 17, 1948 (month) (day) (year)

Cemetery or crematory: Hillcrest Burial Park

Location: Cumberland, Md.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. Dec 17 1948 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 14, 1948 at 11:20 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 12 1948 to DEC 14 1948 and that I last saw ~~him~~ alive on December 14 1948

Immediate cause of death: Myocardial Failure due to Myocardial Degeneration Left Bundle of Brunch Block — DURATION: 2 yrs?

Due to:

~~Due to~~ Recurrent Carcinoma Prostate — DURATION: 1 yr

Other conditions contributing to death: — DURATION: 5

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: 50 Baltimore St. Date signed: 12/16/48

Within corporate limits DR. HODGES

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

160c (N) 12006

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 HOURS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 6 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)

State: PENNSYLVANIA County: Bedford

City or town: MANNS CHOICE
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME
BABY GIRL BOHN

3. (b) Social Security Number
None

4. Sex: FEMALE

5. Color or race: WHITE

6.(a) Single, married, widowed, or divorced: SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): December 30, 1948 @ 11:52 PM

8. AGE: Years | Months | Days | If less than one day: 6 hrs. 20 min.

9. Birthplace: MARYLAND Cumberland, Alleg. Co.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: LLOYD BOHN
13. Birthplace: PENNSYLVANIA

MOTHER
14. Maiden name: EVELYN AMICK
15. Birthplace: PENNSYLVANIA

16. Informant: MEMORIAL HOSPITAL
Address: MEMORIAL AVE.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/31/48 (month) (day) (year)

Cemetery or crematory: Milligan Cove

Location: Buffalo Mills, Pa.

18. Funeral director: Harvey H. Zeigler

Address: Hyndman, Pa.

19. Dec 31, 1948 W. L. Trautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DEC. 31, 1948 at 6:12 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 30 1948 to Dec. 31 1948 and that I last saw her alive on Dec. 30 1948

Immediate cause of death: Prematurity — DURATION 6 hrs

Due to: Premature seperation of placenta.

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: W. Royce Hodges M.D.
M. D. or other

Address: Cumberland, Md. Date signed 12/31/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

DR DEMING

12007

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

164c

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3-DAYS

Hospital, institution, or street address where death occurred:
MEMORAIL HOSPITAL

How long in hospital or institution? 3- DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: GARRETT

City or town: OAKLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
EVELYN BOLYARD

3.(b) Social Security Number
193-22-5604

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) September 17, 1929 ~~DEC. 18, 1928~~

6.(c) If alive, give age years

8. AGE: Years ~~20~~ 19 Months 3 Days ~~4~~ If less than one day hrs. min.

9. Birthplace W. VA (CORINTH)
(Town, county, and state)

10. Usual occupation ~~Cook~~ - Waitress

11. Industry or business WARDS RESTAURANT

MOTHER FATHER

12. Name ALONZO BOLYARD

13. Birthplace NEWBURG W.VA

14. Maiden name ETHEL BLANCH WAGNER

15. Birthplace EGLON W.VA

16. Informant MEMORIAL HOSPITAL

Address cumberland md

17. Removal (Burial, cremation, or removal? Which?) Date thereof DEC. 23, 1948 (month) (day) (year)

Cemetery or crematory Burial Mt. Israel Cem

Location Near Fairmont W. Va

18. Funeral director ~~BOLDEN~~, Emroy Bolden

Address OAKLAND MD

19. ~~DEC 24~~ 1 19 48 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH DEC 21 19 48 at 7:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ~~DEC. 21~~ 19 to 19

and that I last saw her alive on DEAD DEC 21 19 48

Immediate cause of death 2-3 DEGREE BURNS BODY AND FACE — DURATION

Due to GAS EXPLOSIAN FROM LIGHTED CIGARETTE

Due to

Other conditions FRACTURE OF THE TWELFTH DORSAL VETEVRAE AND DISLOCATION
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results SUICIDE, as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date 12/18/48

Where did injury occur? Oakland Md. Garrett County (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury 2-3 Degree Burns Injured at work? No

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H.V. DEMING MD H.V. Deming M.D. M. D. or other

Address CUMBERLAND MD Date signed 12/21/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

McFane

12008

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

74a

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Three weeks

Hospital, institution, or street address where death occurred:
Miners Hospital

How long in hospital or institution? Three weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. ~~Rural~~ E. College Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Agnes Thompson Bond

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Arthur Bond

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): Nov. 27th 1905

8. AGE:

Years	Months	Days	If less than one day
43	1	1	hrs. min.

9. Birthplace: Selbyspert, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Housekeeper

FATHER
12. Name: John Foot
13. Birthplace: Maryland

MOTHER
14. Maiden name: Agnes Ryan
15. Birthplace: Maryland

16. Informant: Arthur Bond
Address: Frostburg, Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 12-31-1948 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg, Md.

18. Funeral director: J. R. Hurst
Address: Frostburg, Md.

19. 12-31 1948 Mrs. Nancy N. Rose
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 28 1948 at 11 00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 24 1948 to Dec 28 1948 and that I last saw her alive on Dec 28 1948

Immediate cause of death	DURATION
Acute Lymphatic Leukemia	2 mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Wm Lane M.D.
M. D. or other

Address: Frostburg Md Date signed 12-29-48

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

912

12009

Reg. Dist. No. 4

M

I

T

VS-A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 Years

Hospital, Institution, or street address where death occurred:
Rt 3, Valley Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt 3, Valley Road
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Wilbert A. Bonner

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Arbella Bonner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 15 1882

8. AGE: Years	Months	Days	If less than one day
66	6	16	..... hrs. ..... min.

9. Birthplace: Harmon, W. Va. Randolph County
(Town, county, and state)

10. Usual occupation: Retired Merchant

11. Industry or business: Grociers

FATHER
12. Name: James Bonner
13. Birthplace: Harmon, W. Va.

MOTHER
14. Maiden name: Phobie White
15. Birthplace: Harmon, W. Va.

16. Informant: Mrs. Iva George

Address: Rt 3, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 1/3/49 (month) (day) (year)

Cemetery or crematory: Mt. Herman

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Jan 3, 1949 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 31 1948, at 4 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1948 to Dec. 31 1948 and that I last saw him alive on Dec. 28 1948

Immediate cause of death	DURATION
Coronary thrombosis	1 hour
Due to: Generalized arteriosclerosis,	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: B. M. Schneider M.D. M. D. or other

Address: 41 Greene St. Date signed: Dec. 31, 1948

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12010

13b

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
Mudlathian Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Mudlathian Road
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: James Aloysius Brady

3. (b) Social Security Number: 220-07-6759

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Genevieve Mummy
6.(c) If alive, give age: 60 years
7. Birth date of deceased (mo., day, yr.): Mar-1-1886
8. AGE: Years: 62 Months: 9 Days: 16 If less than one day: hrs. min.
9. Birthplace: Frostburg, Allegany, Md. (Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Coal Mines
FATHER 12. Name: Charles Brady
FATHER 13. Birthplace: Ireland
MOTHER 14. Maiden name: Marietta Shelley
MOTHER 15. Birthplace: Ireland
16. Informant: Mrs. Dolan Brady
Address: Mudlothian Rd. Frostburg Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-21-1948 (month) (day) (year)
Cemetery or crematory: St. Michaels
Location: Frostburg, Md.
18. Funeral director: Jacob Yoder
Address: Frostburg, Md.
19. 12-20 1948 Mrs. Nancy A. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12-18-48 19 at 10 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 19 48 to 12-18 19 48 and that I last saw him alive on 12-17 19 48

Immediate cause of death	DURATION
respiratory failure	1 day
Due to: pulmonary tuberculosis	10 years
Due to:	
Other conditions: Silicosis	?

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Adolf Waferman M.D. (M. D. or other)
Address: Frostburg, Md. Date signed: 12-20-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

12011

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Rural Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs

Hospital, institution, or street address where death occurred: Amos Knolls Rt #5, Cresaptown

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Amos Knolls Rt #5

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME A Della Houser Brandt

3. (b) Social Security Number

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Wm H Brandt

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 18 1870

8. AGE: Years 78 Months 8 Days 12 If less than one day ..... hrs. ..... min.

9. Birthplace: Altoona Penna. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: at Home.

FATHER

12. Name: Wm Miller Houser

13. Birthplace: Penna.

MOTHER

14. Maiden name: Henrietta Smith

15. Birthplace: Hollidaysburg Pa

16. Informant: Mrs Chas A Richards

Address: Amos Knolls RD #5

17. Burial (Burial, cremation, or removal. Which?) Date thereof Jan 3 '48 (month) (day) (year)

Cemetery or crematory: Oak Ridge Cem.

Location: Altoona, Pa.

18. Funeral director: Louis Stein Inc

Address: Cumberland.

19. Dec. 31, 1948 (Date rec'd by registrar) M D Vannatta Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 30 1948 at 1 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9 1944 to Dec 30 1948 and that I last saw h.. alive on December 19 1948

Immediate cause of death: Cerebrovascular Heart Disease — DURATION: 2 yrs

Due to: cerebrovascular — DURATION: 4 yrs

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L Mills MD M. D. or other

Address: 59 Greene St. Date signed 12-31-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

12012

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, Institution, or street address where death occurred: Miner's Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. No 1
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Thomas Patrick Carter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Catherine Fraetz

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): May 19 - 1874

8. AGE: Years: 74 Months: 7 Days: 6 If less than one day: hrs. min.

9. Birthplace: Vale Summit, Allegany, Md
(Town, county, and state)

10. Usual occupation: Retired Miner

11. Industry or business: Coal Mines

FATHER
12. Name: John Carter
13. Birthplace: Yorkshire

MOTHER
14. Maiden name: Elizabeth Delaney
15. Birthplace: Vale Summit, Md

16. Informant: Leo Carter
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-28-1948 (month) (day) (year).
Cemetery or crematory: St. Michael's Cemetery
Location: Frostburg, Md.

18. Funeral director: Jacob Vafer
Address: Frostburg, Md.

19. 12-27 1948 Mrs. Nancy N Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-25 19 48, at 10 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 48, to Dec. 25 19 48 and that I last saw him alive on Dec. 25-48 19 48.

	DURATION
Immediate cause of death: Heart failure	3 days
Due to: Arteriosclerosis	10 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Adolph Wolferman M.D.
M.D. or other

Address: Frostburg Md. Date signed 12-27-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

12013

Within corporate limits

M E B Owens

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

160c

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred: 209 Emily St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 209 Emily St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Helen Elizabeth Crabtree

3.(b) Social Security Number: None

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): December 4, 1948

8. AGE: Years: 0 Months: 0 Days: 2 If less than one day ... hrs. ... min.

9. Birthplace: Cumberland, Md. (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER 12. Name: William M. Crabtree

13. Birthplace: Cumberland, Md.

MOTHER 14. Maiden name: Maude E. Koegel

15. Birthplace: Cumberland, Md.

16. Informant: William M. Crabtree

Address: 209 Emily St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 7, 1948 (month) (day) (year)

Cemetery or crematory: Hillcrest Burial Park

Location: Cumberland, Md.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. Dec 7, 1948 (Date rec'd by registrar) W. R. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 6, 1948 at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 4, 1948 to Dec 6 48 and that I last saw h... alive on Dec 4, 1948

Immediate cause of death: Prolonged labor, Compression of brain

Due to: Prolonged labor

Due to:

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: M E B Owens M. D. or other

Address: 133 Va Ave Date signed: 12/7/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

M

1

Within corporate limits

12014

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
604 Hill St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 604 Hill St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Gladys Price Daum

3.(b) Social Security Number
214-07-3254

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Frederick O. Daum

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Aug. 24, 1902

8. AGE: Years 46 | Months 3 | Days 24 | If less than one day ... hrs. ... min.

9. Birthplace: Philadelphia, Penna.
(Town, county, and state)

10. Usual occupation: Caffateria

11. Industry or business: Celeanese Corp. Of America

FATHER
12. Name: Benjamin Price
13. Birthplace: Wales

MOTHER
14. Maiden name: Catherine Thomas
15. Birthplace: Wales

16. Informant: Mr. John F. O. Daum
Address: 604 Hill St. Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec. 21, 1948
(month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Dec. 21 19 48 W. R. Trautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 18, 19 48 at 2:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 48 to Dec 18 19 48
and that I last saw her alive on 12/18/48 19

Immediate cause of death: Coronary occlusion

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Chronic cholecystitis

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John K. Rozum M.D.
M. D. or other

Address: Cumberland Md. Date signed 12/20/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

131 b

12115

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg / Borden Shaft

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Borden Shaft

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: John Davis

3. (b) Social Security Number: none

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Florence Davis

6.(c) If alive, give age: 76 years

7. Birth date of deceased (mo., day, yr.): Feb. 24, 1872

8. AGE: Years: 76 Months: 9 Days: 28 If less than one day: hrs. min.

9. Birthplace: Middlethin-Alleg-Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER

12. Name: Wm R. Davis

13. Birthplace: Wales

MOTHER

14. Maiden name: Mary Ann Read

15. Birthplace: Scotland

16. Informant: Archie Davis

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24-1948 (month) (day) (year)

Cemetery or ~~crematory~~: Allegany

Location: Frostburg, Md.

18. Funeral director: J. R. Dunkel

Address: Frostburg, Md.

19. 12-24 1948 Mrs. Nancy H. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 22 1948 at 11:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 26 1948 to Dec 22 1948 and that I last saw him alive on Dec 21 1948

Immediate cause of death: Chr Nephritis — DURATION: Several months

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: W. D. M. Lane M.D. M. D. or other

Address: Frostburg Md. Date signed: 12-24-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Within corporate limits

DR.R.WMS 1454

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a cp

12016

Reg. Dist. No.

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11HRS

Hospital, institution, or street address where death occurred: MEMORIAL GOSPITAL

How long in hospital or institution? 11 HRS.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Pennsylvania County: ALLEGANY

City or town: [redacted] Rt. 3 Lake Gordon Road (If outside city or town limits, write RURAL and give nearest town)

Street No.: Near CUMBERLAND Maryland Rural (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARTIN L DEREMER

3.(b) Social Security Number: 214-05-9621

4. Sex: MALE

5. Color or race: WHITE

6.(a) Single, married, widowed, or divorced: MARRIED

6.(b) Name of husband or wife: LENA LEASURE

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): oct.31,1883

8. AGE: Years 65 Months ~~10~~ 1 Days 21 If less than one day ... hrs. ... min.

9. Birthplace: PENNsylvania (Town, county, and state)

10. Usual occupation: NONE - Retired Farmer

11. Industry or business

MOTHER FATHER

12. Name: GEORGE DEREMER

13. Birthplace: PENN.

14. Maiden name: JANE DICKEN

15. Birthplace: PENN

16. Informant: MEMORIAL HOSPITAL

Address: CUMBERLAND MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/24/48 (month) (day) (year)

Cemetery or crematory: Zion Memorial Burial Park

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Dec. 24 1948 (Date rec'd by registrar) W.R. Faust M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DEC. 22, 19 48 at 2:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/21/46 19 to 12/22/48 19 and that I last saw h... alive on 12/22/48 19

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to: Arteriosclerosis	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R.H. Williams M.D. M. D. or other

Address: Cumberland Md. Date signed: 12/23/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97

12017

Reg. Dist. No. 8

1. PLACE OF DEATH

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 37 years

Hospital, Institution, or street address, where death occurred: High Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No.: High Street (If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME Nannie Symons Devlin

3. (b) Social Security Number –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband ~~or wife~~: Terrence J. Devlin

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Aug. 24, 1881.

8. AGE: Years: 67 Months: 3 Days: 23 If less than one day: ..... hrs. ..... min.

9. Birthplace: Barton Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER

12. Name: John Symons

13. Birthplace: Barton

MOTHER

14. Maiden name: Alice Nicholds

15. Birthplace: Stony Run (near Barton)

16. Informant: Miss Anna Devlin

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 16, 1948 (month) (day) (year)

Cemetery or crematory: St. Marys Cemetery

Location: Lonaconing, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md.

19. Dec 16 1948 Jeannette McGoal (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/14 1948 at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/19 1948 to 12/15 1948 and that I last saw h. alive on 12/13 1948

Immediate cause of death: Circulatory collapse

Due to (1) Cardiac Arrythmia (4) Arrythmia

Due to (2) Hypertension

Due to (3) Arteriosclerosis

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul Eugene Dye M.D. M. D. or other

Address: Lonaconing, Md. Date signed: 12/15/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Within corporate limits

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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12018

552

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 603 SCHLEY STREET
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
MR. WILLIAM DOLEMAN

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	COLORED	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MAY 29, 1876

8. AGE: Years	Months	Days	If less than one day
72	7	4	hrs. min.

9. Birthplace: VIRGINIA
(Town, county, and state)

10. Usual occupation: RETIRED

11. Industry or business

FATHER
12. Name: HUMPHREY DOLEMAN
13. Birthplace: VIRGINIA

MOTHER
14. Maiden name: ALICE WILLIAMS
15. Birthplace: VIRGINIA

16. Informant: MEMORIAL HOSPITAL
Address: MEMORIAL AVE., CITY

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 6, 1948 (month) (day) (year)

Cemetery or crematory: Cemetery

Location: Franklin Town, W. Va.

18. Funeral director: John C. Wolford
Address: 125 S Liberty St

Dec. 3, 1948 (Date rec'd by registrar) W. L. Fantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 3, 1948 at 4:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h... 1m alive Dead Dec. 3 1948

Immediate cause of death: Pulmonary embolism — DURATION: about 20 min.

Due to: Bronchial carcinoma — DURATION: several years

Due to: — DURATION:

Other conditions: — DURATION:

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. (M. D. or other)

Address: Cumberland Md Date signed: 12-3-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

I

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

169

12019

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: In ambulance, route 51 to hospital
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Dead on arrival at Memorial Hospital
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 241 Williams St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Thomas Edward Donnelly

3. (b) Social Security Number
705-07-9721

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	divorced

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 7-1886

8. AGE: Years 62 | Months 2 | Days 4 | If less than one day hrs. min.

9. Birthplace: Green Ridge Md.
(Town, county, and state)

10. Usual occupation: Freight conductor

11. Industry or business: B&O.R.Ry.

FATHER
12. Name: Thomas Donnelly
13. Birthplace: Ireland

MOTHER
14. Maiden name: Rose Ann Darkey
15. Birthplace: Md.

16. Informant: Catherine Donnelly
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 14th '48 (month) (day) (year)
Cemetery or crematory: St Francis Cem.
Location: Oldtown, Md.

18. Funeral director: Louis Stein Inc.
Address: Cumberland, Md.

19. Dec 13 1948 (Date rec'd by registrar) W.K. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11 1948 at about 7.10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw him alive Dead Dec. 11 1948

Immediate cause of death: Intrathoracic & Intra abdominal hemorrhage — DURATION: about 20 minutes

Due to: a crushed chest, fractured liver, left diaphragm & pelvis, also had a fracture of the 9th &10th dorsal vetrebrae, compound

Other conditions: comminuted fracture of the lower left leg.
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: R.Ry. accident Date of: 12-11-48
Where did injury occur? Paw Paw, Morgan, W.Va. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) B&O R.Ry. Paw Paw W.Va.
Means of injury: Caught Between Two Freight cars. Injured at work? yes

Deputy Medical Examiner - Allegany

23. SIGNATURE: H.V. Deming M.D. H.V. Deming M.D. M. D. or other
Address: Cumberland Md. Date signed: 12-11-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH INDELIBLE INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d JB

12020

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one day

Hospital, institution, or street address where death occurred: Allegany Hospital, Cumb., Md.

How long in hospital or institution? one day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: W. Virginia County: Mineral

City or town: Keyser
(If outside city or town limits, write RURAL and give nearest town)

Street No. 115 Mozelle St.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME

Ella Maud Douglass

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	Widowed

6.(b) Name of husband or wife: Adam V. Douglass

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov. 11, 1871

8. AGE: 77 Years | Months 1 | 2 Days | If less than one day ..... hrs. ..... min.

9. Birthplace: Preston County, W. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER 12. Name: John W. Matlick

13. Birthplace: Preston Co. W. Va

MOTHER 14. Maiden name: Rebecca A. Conn

15. Birthplace: Preston Co., W. Va

16. Informant: Richard M. Douglass

Address: 511 Talbert St., Cumb., Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 16, 1948 (month) (day) (year)

Cemetery or crematory: Queens Point Cemetery

Location: Keyser, W. Va.

18. Funeral director: B. W. Mantywood

Address: Keyser, W. Va.

19. Dec. 29 1948 W. R. Grant, M.D. Registrar
(Date rec'd by registrar) per T

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 13, 1948 at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-12- 1948 to 12-13- 1948

and that I last saw him alive on 12-13- 1948

Immediate cause of death	DURATION
congestive heart failure	6 weeks
Due to: arteriosclerotic heart disease	6 months
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: L. Kling M.D. M. D. or other

Address: 06 Greene St. Date signed: 12-13-48

Within corporate limits DR. W.F. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 12121 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~41 DAYS~~ 22 years

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 41 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 134 BEDFORD STREET
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
MR. JAMES E. DUCKWORTH

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife: AGNES HOLMES

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JAN. 22, 1878

8. AGE: Years 70 | Months ~~11~~ 10 | Days ~~19~~ 27 | If less than one day ..... hrs. ..... min.

9. Birthplace: Maryland, Lonaconing
(Town, county, and state)

10. Usual occupation: NONE

11. Industry or business

FATHER
12. Name: JAMES S. DUCKWORTH
13. Birthplace: MARYLAND

MOTHER
14. Maiden name: LOUISE DUCKWORTH
15. Birthplace: MARYLAND

16. Informant: MEMORIAL HOSPITAL
Address: MEMORIAL AVE.,

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 21, 1948 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Dec 21 1948 (Date rec'd by registrar) W.R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 19, 1948 at 3:34 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 7 1948 to Dec. 19 1948 and that I last saw him alive on Dec. 18 1948

Immediate cause of death: Chronic Myocardial Degeneration

Due to: Generalized Arteriosclerosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. ~~or other~~

Address: Cumberland Date signed 12/19/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

12122

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 years

Hospital, Institution, or street address where death occurred:
Allegany County Infirmary

How long in hospital or institution? 5 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. Ormond St.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
ANNIE EISEL

3. (b) Social Security Number
none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: William Eisel

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): December 21, 1865

8. AGE: Years 82 | Months 11 | Days 16 | If less than one day ____ hrs. ____ min.

9. Birthplace: Frostburg, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business: home

FATHER
12. Name: Henry Offman,
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine Lemmert,
15. Birthplace: Germany

16. Informant: Harry Eisel,
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 10 '48 (month) (day) (year)
Cemetery or crematory: Zion Evan. & Reform. Cemetery
Location: Frostburg, Md.

18. Funeral director: J. R. Durst,
Address: Frostburg, Md.

19. Dec 9, 1948 (Date rec'd by registrar) W. R. Kantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 7, 1948, at 2:15 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1946 to Dec. 7 1948
and that I last saw h. alive on Dec. 7 1948

Immediate cause of death	DURATION
Myocardial failure	2 wks
Due to: Generalized Arteriosclerosis	4 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Arthur T. Jones M.D. M. D. or other
Address: 110 S. Centre St Date signed: 12-9-48

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

12023

181

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life time

Hospital, Institution, or street address where death occurred:
Miners Hospital, Frostburg Md.

How long in hospital or institution? 11 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 231 Welsh Hill
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3. (a) FULL NAME: James Dewey Felker

3. (b) Social Security Number: 214-12-3099

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Genevieve M. Felker

6.(c) If alive, give age: 23 years

7. Birth date of deceased (mo., day, yr.): July 31- 1920

8. AGE:

Years	Months	Days	If less than one day
28	4	25	hrs. min.

9. Birthplace: Meyersdale Pa.
(Town, county, and state)

10. Usual occupation: Machinest helper

11. Industry or business: B&O.R.Ry.

FATHER
12. Name: Frank Felker
13. Birthplace

MOTHER
14. Maiden name: Grace Lambert
15. Birthplace

16. Informant: Mrs. James D. Felker

Address: 215 Welsh Hill Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-28-48 (month) (day) (year)

Cemetery or crematory: Eckhart Cemetery

Location: Eckhart, Md.

18. Funeral director: Jacob Hafer

Address: Frostburg Maryland

19. 12-27 1948 Mrs. Harvey N. Rice
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 25 1948 at 215P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...

and that I last saw him alive on Dec. 25 1948

Immediate cause of death: 2nd. & 3rd. degree burns, chest arms, face & feet — DURATION: about 12 hours

Due to: kitchen gas stove exploded.

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 12-25-48

Where did injury occur? Frostburg (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Kitchen gas stove exploded Nature of injury: his clothes caught fire no

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V. Deming M.D. H.V. Deming M.D.
M. D. or other

Address: Cumberland Md. Date signed: 12-26-48

Within corporate limits

DR. ROBINSON

Base on Weight when signed

159

12024

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 1

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 HOURS

Hospital, Institution, or street address where death occurred:

MEMORIAL HOSPITAL

How long in hospital or institution? 8 HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: WEST VIRGINIA County: Hampshire

City or town: GREEN SPRING

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME

FOLEY, BABY BOY

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) DECEMBER 23, 1948

8. AGE:

Years	Months	Days	If less than one day
		1	..... hrs. ..... min.

9. Birthplace: Green SPRING, W.VA.

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name: FOLEY, CARL

13. Birthplace: WEST VIRGINIA

MOTHER

14. Maiden name: LAMBERT, ELEANOR

15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL

Address: MEMORIAL AVE.,

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24 1948 (month) (day) (year)

Cemetery or ~~crematory~~: Forest Glenn

Location: Green Spring, W.Va (Rural)

18. Funeral director: John F. Henderson

Address: Sheffield W.Va.

19. Dec. 24, 1948 (Date rec'd by registrar) W. R. Bank, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 24, 1948 at 2:55A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 23 1948, to ..... 19..

and that I last saw him alive on Dec 23 1948

Immediate cause of death: Respiratory failure

Due to: Prematurity

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ..... Injured at work?

23. SIGNATURE: F. Bowman Robinson M.D. M. D. or other

Address: 19 S. Liberty St. Date signed 12/24/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V2 415 9-45-15M

12625

1640

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
home) 234 N. Mechanic St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 234 N. Mechanic St.
(If rural, give LOCATION)

2.(a) If veteran, name war: World war 11

3. (a) FULL NAME: Vernard Olin Garlitz

3. (b) Social Security Number: 217-14-4421

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Arlena Burdock Garlitz

6.(c) If alive, give age: 25 years

7. Birth date of deceased (mo., day, yr.): Sept 15 - 1917

8. AGE: Years	Months	Days	If less than one day
31	3	15	hrs. min.

9. Birthplace: Garrett Co.
(Town, county, and state)

10. Usual occupation: laborer, acetate dept.

11. Industry or business: Celanese Corp. of Am.

FATHER
12. Name: Norman Garlitz
13. Birthplace: Frostburg Md.

MOTHER
14. Maiden name: Rhoda Robison
15. Birthplace: Garrett Co. Md.

16. Informant: Wife- Arlena B Garlitz

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 2-49 (month) (day) (year)

Cemetery or crematory: Blocher Cemetary

Location: Garrett Co.

18. Funeral director: Joseph R. Durst

Address: Frostburg, Md.

19. 1-2 1949 Mrs. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 30 1948 at about 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dead Dec. 30 1948

Immediate cause of death	DURATION
Strangulation	about 10 min.
Due to: hanging himself with a chain around his neck.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Suicide Date of: 12-30-48

Where did injury occur? Frostburg (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Hung himself with a chain

Deputy Medical Examiner - Allegany

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address: Cumberland Md. Date signed: 12-30-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

Within corporate limits

12026

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

119a

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
109 So. Lee St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 So. Lee St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
Cathie Ann George

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	infant

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 11, 1948

8. AGE:

Years	Months	Days	If less than one day
	5	10	... hrs. ... min.

9. Birthplace: Cumberland, Md.
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Harry Wayne George
13. Birthplace: South Fork, Penna.

MOTHER
14. Maiden name: Dorothy May Winters
15. Birthplace: Cumberland, Md.

16. Informant: H. Wayne George
Address: 109 So. Lee St. Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec. 23, 1948
(month) (day) (year)

Cemetery or crematory: HillCrest Burial Park

Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Dec. 23, 1948
(Date rec'd by registrar)
W. R. Kautz, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 21, 1948, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 Dec 1948, to 21 Dec 1948, and that I last saw h. alive on 20 Dec 1948.

	DURATION
Immediate cause of death: Cerebral Anoxia.	5 days
Due to: Generalized Septaemia	
Due to: Intestinal infection	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. S. Cooper M. D.
M. D. or other

Address: 101 S. Center St. Date signed: 22 Dec 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-1

12127

159

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred: Meners Hospital

How long in hospital or institution? 10 hrs

2. USUAL RESIDENCE (HOME) OF DEceased:

(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: FROSTBURG

(If outside city or town limits, write RURAL and give nearest town)

Street No. 38 CENTENIAL STREET

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Baby Glass

3. (b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Infant

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Dec 6 1948

8. AGE: Years | Months | Days | If less than one day: 10 hrs. 11 min.

9. Birthplace: Frostburg Md (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER 12. Name: Francis Glass

13. Birthplace: Md

MOTHER 14. Maiden name: Doris Finzel

15. Birthplace: Md

16. Informant: Doris Finzel Glass

Address: Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 9 - 1948 (month) (day) (year)

Cemetery or crematory: Finzel

Location: Garrett Co.

18. Funeral director: J.R. Dugan

Address: Frostburg, Md

19. 12-9 1948 (Date rec'd by registrar) Nancy H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 6 1948 at 2:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 6 1948 to Dec 6 1948 and that I last saw him alive on Dec 6 1948

Immediate cause of death: Premature birth

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. O. M. Lane M.D. M. D. or other

Address: Frostburg Md Date signed 12-8-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully; correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

12128

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 130 McCullah St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No.: 130 McCullah St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Rose Greco

3.(b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Joseph Greco

6.(c) If alive, give age: 72 years

7. Birth date of deceased (mo., day, yr.): October 4 1889

8. AGE: Years 59 Months 2 Days 13 Unless than one day: hrs. min.

9. Birthplace (Town, county, and state): Italy

10. Usual occupation: Housewife

11. Industry or business: home

FATHER

12. Name: Guy Bishield

13. Birthplace: Italy

MOTHER

14. Maiden name: Ursula Emprenia

15. Birthplace: Italy

16. Informant: Joseph Greco

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 20 '48 (month) (day) (year)

Cemetery or crematory: St. Michael's Cemetery

Location: Frostburg, Md.

18. Funeral director: J. R. Durst

Address: Frostburg Md.

19. 12-20 1948 Mrs Hazel V. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 17 1948 at 5:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from DECEMBER 15 1948 to DECEMBER 17 1948 and that I last saw her alive on DECEMBER 15 1948

Immediate cause of death	DURATION
Acute Myocardial Insufficiency	15 minutes
Due to Rheumatic Heart Disease	— YRS.
HYPERTENSION	— YRS.
to with AURICULAR FIBRILLATION	— YRS.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: NONE PERFORMED

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NONE

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Markile Pothate M.D. M. D. or other

Address: 48 Broadway - Frostburg Md. Date signed 12/20/48

12029

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97/450

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Gilmore (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 55 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Gilmore (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: No - None

3.(a) FULL NAME: Amos Green

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

8.(b) Name of husband or wife: Rebecca Poland Green

8.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): March 28, 1858

8. AGE: Years: 90 Months: 9 Days: 3 If less than one day: hrs. min.

9. Birthplace: New Germany, Garrett Co. Md (Town, county, and state)

10. Usual occupation: Laborer - Retired (20 yrs)

11. Industry or business: Various places -

FATHER 12. Name: Jefferson Green

13. Birthplace: Farm - Garrett Co. Md

MOTHER 14. Maiden name: Lydia Broadwater

15. Birthplace: Farm. Garrett Co., Md

16. Informant: Miss Jane Green

Address: Gilmore, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Jan. 3, '49 (month) (day) (year)

Cemetery or crematory: Old Coney Cemetery

Location: Knapps Meadow, Lonaconing

18. Funeral director: M. Eichhorn Md

Address: Lonaconing, Md

19. Jan 4 1949 (Date rec'd by registrar) Annette M. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 31st 1948 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/— 1948 to 12/31 1948 and that I last saw him alive on 12/21/48 1948

Immediate cause of death: Malnutrition Arteriosclerosis

DURATION

Due to: Old Age

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul Eugene Fry, M.D. M. D. or other

Address: Lonaconing Md Date signed: 1/3/49

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

12030

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

462

Reg. Dist. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46

Hospital, institution, or street address where death occurred: Douglas Avenue

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No.: Douglas ave. (If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME William T. Green

3.(b) Social Security Number –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –

6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): Jan 27, 1902.

8. AGE: Years	Months	Days	If less than one day
46	10	21	hrs. min.

9. Birthplace: Lonaconing, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business: None

FATHER 12. Name: Wm E. Green

13. Birthplace: Lonaconing, Md.

MOTHER 14. Maiden name: Jessie Trezise

15. Birthplace: Lonaconing, Md.

16. Informant: Marvin Green

Address: Lonaconing, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 21, 1948 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md

19. Dec 21 1948 (Date rec'd by registrar) Jannette M. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12/18 1948, at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1947 to 12/18 1948 and that I last saw him alive on 12/14/48

Immediate cause of death: Intestinal Hemorrhage

Due to: Carcinoma of Intestine

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

DURATION

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Paul Eugene Frye M.D. M.D. or other

Address: Lonaconing, Md Date signed: 12/21/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

Within corporate limits

14-4

DR. F. WMS

12031

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

B1a CD

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY COUNTY

City or town: CUMBERLAND MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DEACESED:
(If institution, infants, give residence of mother)

State: WEST VIRGINIA County: Morgan

City or town: BERKELEY SPRING
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME
MRS. MAMIE E. HENRY

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	W	MARRIED

6.(b) Name of husband or wife: WILLIAM C. HENRY
DECEASED 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): APRIL 6, 1886

8. AGE: Years	Months	Days	If less than one day
62	8	6	..... hrs. ..... min.

9. Birthplace: BERKELEY SPRINGS .W.VA
(Town, county, and state)

10. Usual occupation: HWIFE

11. Industry or business

FATHER
12. Name: THOMAS JOHNSON
13. Birthplace: WEST VIRGINIA

MOTHER
14. Maiden name: ELIZABETH EVERSOLE
15. Birthplace: WEST VIRGINIA

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND. MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/15/48 (month) (day) (year)

Cemetery or crematory: Greenway Cemetery

Location: Berkeley Springs W Va

18. Funeral director: F. D. Parsons

Address: Berkeley Springs W.Va

19. Dec 14, 1948 (Date rec'd by registrar) W. R. Smith, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 12-12 1948 at 9:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-17 1948 to 12/12 1948 and that I last saw her alive on 12/12 1948.

Immediate cause of death	DURATION
Cardiovascular	
Due to: Renal disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. or other

Address: Cumberland Date signed 12/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

836

12132

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 106 Wempe Dr.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
Mabel Hyde

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Walter Hyde

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan. 29, 1889

8. AGE:

Years	Months	Days	If less than one day
59	11	0	..... hrs. ..... min.

9. Birthplace: Eckhart, Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Thomas Sampson
13. Birthplace: England

MOTHER
14. Maiden name: Mary Jane Jennings
15. Birthplace: England

16. Informant: Mrs. John Meleri

Address: 106 Wempe Dr. Cumberland, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Jan. 2, 1949
(month) (day) (year)

Cemetery or crematory: Allegany Cem.

Location: Frostburg, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Jan. 1, 1949 W. L. Trautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 29, 1948 at 4:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1948 to Dec 29 1948 and that I last saw her alive on Dec 29 1948

	DURATION
Immediate cause of death: Cerebral Thrombosis	14 days
Due to: Cerebral Arteriosclerosis	1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. W. Trewaskis, Jr. M. D. or other

Address: Cumberland, Md. Date signed: 12/30/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

12033

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All her life
Hospital, institution, or street address where death occurred:
68 West Union Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 68 W. Union St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Eva Hitchins Jeffries

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Feb. 6. 1882

8. AGE: Years	Months	Days	If less than one day
66	10	4	hrs. min.

9. Birthplace: Frostburg, Allegany Co., Md. (Town, county, and state)
10. Usual occupation: Home Manager for Single Bros
11. Industry or business

FATHER
12. Name: Samuel Jeffries
13. Birthplace: Near Bristol England

MOTHER
14. Maiden name: Mary Susan Hocking
15. Birthplace: St Just, Cornwall, England

16. Informant: Charles S. Jeffries
Address: 68 West Union St, Frostburg, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 13-48 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Maryland
18. Funeral director: Frostburg Furn"& Undertaking Co
Address: Frostburg, Maryland
J. R. Albert
19. 12-13 (Date rec'd by registrar) 19 48 Mrs Harvey N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 10 1948 at 6.25 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from april 8 1947 to December 10 1948
and that I last saw h. alive on December 10 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage.	6 mos.
Due to: arterio-sclerosis	
Chronic myocarditis.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other
Address: Frostburg, Md. Date signed: 12.13.48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Within corporate limits

12034

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: 309 Harrison St. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
309 Harrison St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 309 Harrison St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
Virginia Katherine Judy

3. (b) Social Security Number
None

4. Sex: female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widow

6.(b) Name of husband or wife: Michael Judy

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Jan. 3. 1880

8. AGE: Years 68 | Months 11 | Days 13 | If less than one day ... hrs. ... min.

9. Birthplace: Petersburg W.Va.
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

MOTHER FATHER

12. Name: Jacob Ours

13. Birthplace: Petersburg W.Va.

14. Maiden name: Sarah Ours

15. Birthplace: Petersburg W.Va.

16. Informant: Jacob H. Judy

Address: 68 Cresap St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 20, 1948 (month) (day) (year)

Cemetery or crematory: Hillcrest Burial Park

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Dec. 18, 1948 (Date rec'd by registrar) W.R. Fauntz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 16 19 48 at 10.45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19 ... to ... 19 ... and that I last saw her alive Dead Dec. 16 19 48

Immediate cause of death: Right heart failure — DURATION: at once

Due to: coronary sclerosis and adhesive pericarditis — several years

Due to:

Other conditions: pulmonary fibrosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H.V. Deming M.D. H.V. Deming M.D. M. D. or other

Address: Cumberland Md. Date signed: 12-16-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45-1

Within corporate limits

12035

107

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: 505 South St. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 months

Hospital, institution, or street address where death occurred:
505 South St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 505 South St.
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME
Barbara Ann Kesner

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Oct. 13- 1948

8. AGE:

Years	Months	Days	If less than one day
0	2	4	... hrs. ... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: William Marshall Kesner
13. Birthplace: Frostburg Md.

MOTHER
14. Maiden name: Betty Berdine Collins
15. Birthplace: Cumberland Md.

16. Informant: Mother)
Address

17. Burial — Date thereof: Dec. 19, 1948
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory: Mt. Herman Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Dec. 19 1948 W. K. Frantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 17 1948 at 9.45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...

and that I last saw h...er alive Dead Dec. 17 1948

Immediate cause of death: Broncho-pneumonia — DURATION: about 1 week

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

~~Deputy Medical Examiner - Allegany Co.~~
Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D.
M.D. or other

Address: Cumberland Md. Date signed: 12-17-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

12036

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport, (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Native

Hospital, Institution, or street address where death occurred: 312 Front Street,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport, (If outside city or town limits, write RURAL and give nearest town)

Street No. 312 Front (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Daniel Warren Kooken

3.(b) Social Security Number: 216-07-9628.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ethel Kooken.

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 4, 1877.

8. AGE:

Years	Months	Days	If less than one day
71	2	29	..... hrs. ..... min.

9. Birthplace: Westernport, Allegany, Md. (Town, county, and state)

10. Usual occupation: Retired.

11. Industry or business: West Va. Pulp & Paper Co.

FATHER — 12. Name: Do not know.

FATHER — 13. Birthplace: Do not know

MOTHER — 14. Maiden name: Do not know.

MOTHER — 15. Birthplace: Do not know.

16. Informant: Mrs. Ethel Kooken,

Address: Westernport, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-5-48. (month) (day) (year)

Cemetery or crematory: Philos Cemetery.

Location: Westernport, Md.

18. Funeral director: W. Howard Fridlock

Address: Piedmont, West Va.

19. Dec 5 1948 (Date rec'd by registrar) R. Barnhart Reg. Mgr. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 3, 1948. 19..... at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1 1948 to Dec 3 1948 and that I last saw him alive on Nov 30 1948

Immediate cause of death	DURATION
Hypertensive cardiovascular disease with angina	
Due to: heart failure	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James Gerstner Jr. M.D. M. D. or other

Address: Piedmont W. Va. Date signed 12-4-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

Dr P.E. Berry
932
V2137

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
303 Walnut Street

How long in hospital or institution? - - - - - -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 303 Walnut Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
THOMAS ZEDDOCK KOOKEN

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife: Grace Rine Kooken

6.(c) If alive, give age - - years

7. Birth date of deceased (mo., day, yr.): May 8, 1870

8. AGE:

Years	Months	Days	If less than one day
78	6	28	hrs. min.

9. Birthplace: Barton, Allegany, Maryland
(Town, county, and state)

10. Usual occupation: Beaterman

11. Industry or business: W. Va. Pulp and Paper Co.

FATHER
12. Name: John Kooken
13. Birthplace: New Creek, W. Va.

MOTHER
14. Maiden name: Sarah ~~XXXXXXX~~ Gilbert
15. Birthplace: England

16. Informant: V. Browne Kooken
Address: Westernport, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 8, 1948 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Maryland

18. Funeral director: Ellsworth S. Boal
Address: Westernport, Maryland

19. Dec 8 1948 (Date rec'd by registrar) Zkraynthe Bar M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 6 1948 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 1942 to Dec 6 1948 and that I last saw him alive on Dec 6 1948

	DURATION
Immediate cause of death: Chronic Myocarditis	6 yrs
Due to:	
Due to:	
Other conditions: Chronic Bronchitis	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: P.E. Berry M.D.
M. D. or other

Address: Piedmont W. Va. Date signed: 12/7/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Within corporate limits?

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

12638

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 Days

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No.: Route 2 (If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Louella Clara LaRue

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Cecil LaRue

6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): April 23-1908

8. AGE: Years 40 Months 7 Days 26 If less than one day hrs. min.

9. Birthplace: Frostburg, Allegany, Md. (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business:

FATHER 12. Name: Peter Cafaro

13. Birthplace: Tarpette County

MOTHER 14. Maiden name: Clara Jane Repine

15. Birthplace: Tarpette County

16. Informant: Mrs. Cecil LaRue

Address: Route 2 Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12-22-1948 (month) (day) (year)

Cemetery or crematory: Funsel Cemetery

Location: Funsel, Md.

18. Funeral director: Jacob Hafer

Address: Frostburg, Md.

19. Dec. 20, 1948 (Date rec'd by registrar) W. L. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 19, 1948, at 7:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 16, 1948, to Dec. 19, 1948 and that I last saw her alive on December 18, 1948

Immediate cause of death: Coronary heart disease — DURATION:

Due to: Coronary thrombosis, posterior pattern. — Since Oct., 1948

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results: No autopsy.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. Alfred Von Oven, M. D. or other

Address: 110 S. Centre St. Cumb. Md. Date signed: Dec. 20, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

Within corporate limits

12040

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No.: New Row
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME
LYDIA GERTRUDE LEASURE

3. (b) Social Security Number
none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Hayes Leasure

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): February 9, 1879

8. AGE:

Years	Months	Days	If less than one day
69	10	8	____ hrs. ____ min.

9. Birthplace: Hampshire Cty., W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Joseph Johnson,
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Elizabeth Largent,
15. Birthplace: West Virginia

16. Informant: Mrs. Chas. Leasure,
Address: Mt. Savage, Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec. 20 '48
(month) (day) (year)

Cemetery or crematory: Methodist Cemetery,
Location: Mt. Savage, Md.

18. Funeral director: J. R. Durst,
Address: Frostburg, Md.

19. Dec 19, 1948 W. R. Bantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 18, 1948 at 4.08 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 7, 1948 to December 18, 1948 and that I last saw her alive on December 18, 1948

	DURATION
Immediate cause of death: Cerebral Hemorrhage	10 days
Due to: Generalized Arteriosclerosis	
Due to: Hypertensive Heart Disease	10 yrs.
Diabetes Mellitus	2 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: None

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James P. Hallinan M.D.
M. D. or other

Address: Mt Savage Md Date signed: 12-18-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

Mr. Robinson

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1648 12139

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 Years

Hospital, institution, or street address where death occurred:
307 Pulaski St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 307 Pulaski St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Mrs. Margaret Lebeck

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	married

6.(b) Name of husband or wife: Louis Lebeck

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): July 16-1887

8. AGE: Years	Months	Days	If less than one day
61	4	16	hrs. min.

9. Birthplace: Frostburg, Allegany Co., Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: George Burdock
13. Birthplace: England

MOTHER
14. Maiden name: Agnes Morrison
15. Birthplace: England

16. Informant: Louis Lebeck
Address: Cumberland Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: 12/5/48 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. Dec. 4, 1948 W. R. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 2 1948 at about 4.30P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h er alive on Dead Dec. 2 1948

Immediate cause of death: Exsanguination — Duration: about 10 min.

Due to: (suicide) cut throat. Right internal jugular & trachea servered.

Due to: despondancy

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: suicide Date of: 12-2-48

Where did injury occur? Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?): home

Means of injury: Cut throat with butcher knife & safety razor blade.

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D.
M. D. or other

Address: Cumberland Md. Date signed: 12-2-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Within corporate limits

Schindler

12041

46b

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 years

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 854 Maryland Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Max Lent

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	White	Widowed

6.(b) Name of husband or wife: Anna Shastek

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): May 3, 1892

8. AGE:

Years	Months	Days	If less than one day
56	7	24	... hrs. ... min.

9. Birthplace: Minsk, Russia
(Town, county, and state)

10. Usual occupation: Retail furniture dealer

11. Industry or business

FATHER
12. Name: Reuben Lent
13. Birthplace: Russia

MOTHER
14. Maiden name: ?
15. Birthplace: Russia

16. Informant: Louis Levine

Address: Washington, D.C.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 28 1948 (month) (day) (year)

Cemetery or crematory: East View Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hofer

Address: Cumberland, Md.

19. Dec. 28, 1948 (Date rec'd by registrar) W. L. Bantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 27 1948, at ... M

21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from Sept 1 1948 to December 27 1948 and that I last saw him alive on Dec. 27 1948

Immediate cause of death: Carcinoma of Stomach

	DURATION
Due to	months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: B. M. Schindler M.D.
M. D. or other

Address: 4 Greenway Date signed: Dec. 28, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

within corporate limits

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

162a

12142

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Alleghany

City or town: [redacted] Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Week

Hospital, institution, or street address where death occurred:

Alleghany County Home

How long in hospital or institution? Week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Alleghany

City or town: Ellerslie

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Joseph Edward Lowery

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Anna Daniel Lowery

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Sep. 4, 1879

8. AGE:

Years	Months	Days	If less than one day
69	3	0	hrs. min.

9. Birthplace: Palo Alto Bedford Co., Penna.

(Town, county, and state)

10. Usual occupation: Celanese Worker

11. Industry or business: Textile

FATHER

12. Name: Lewis K. Lowery

13. Birthplace: Pa.

MOTHER

14. Maiden name: Emma L. Lowery

15. Birthplace: Pa.

16. Informant: Anna Lowery

Address: Ellerslie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 7, 1948 (month) (day) (year)

Cemetery or crematory: Palo Alto

Location: Londonderry Twp., Bedford Co., Pa.

18. Funeral director: Harvey H. Zeigler

Address: Hyndman, Pa.

19. Dec 7 19 48 (Date rec'd by registrar) W. L. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 4, 1948, at 2:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1946, to Dec 4 1948

and that I last saw him alive on Nov 29 1948

Immediate cause of death: Senile Psychosis — DURATION 1½ yrs.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John A Topper MD M. D. or other

Address: Hyndman Pa. Date signed: 12-6-48

Within corporate limits

DR. SIMONS
EVIDENCE FOR ADDITION IN #21 SHOWN ON!

FILM No. G 116 JAN 25 1949

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12043

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ HOURS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 2½ HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: LONACONING, MD.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: ROBBIN STREET
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME
SAMUEL LYNCH

3. (b) Social Security Number
none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	MARRIED

6.(b) Name of husband or wife: JENNIE SHROUT

6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): MAY 28, 1882

8. AGE:

Years	Months	Days	If less than one day
66	7	26	hrs. min.

9. Birthplace: MARYLAND
(Town, county, and state)

10. Usual occupation: NONE

11. Industry or business

FATHER
12. Name: JOHN LYNCH
13. Birthplace: W. VA.

MOTHER
14. Maiden name: BRIDGET GARNDER
15. Birthplace: ENGLAND

16. Informant: MEMORIAL HOSPITAL
Address: MEMORIAL AVENUE

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 27 48 (month) (day) (year)

Cemetery or crematory: Oak Hill Cemetery

Location: Lonaconing, Md

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md

19. Dec 26, 1948 (Date rec'd by registrar) W. L. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 24 1948 at 6:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 24 1948 to December 24 1948 and that I last saw him alive on Dec 24 1948

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Pneumonia, bronchial [1/25/49 abc]	
Due to: Hypertension	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: George M. Simon M. D. or other

Address: 12 Union St Date signed: 12/24/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

12044

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 10

1. PLACE OF DEATH:

County: Allegany

City or town: Mt. Savage

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Gertrude Matilda Malloy

3. (b) Social Security Number None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): July 28 1876

8. AGE: Years 72 Months 4 Days 21 If less than one day ... hrs. ... min.

9. Birthplace: Mt Savage Allegany Md (Town, county, and state)

10. Usual occupation: home

11. Industry or business

FATHER

12. Name: George H. Malloy

13. Birthplace: New York

MOTHER

14. Maiden name: Mary E. Deffe

15. Birthplace: Pennsylvania

16. Informant: Mrs. Nellie Taylorow

Address: Mt Savage Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 22 1948 (month) (day) (year)

Cemetery or crematory: St. Patrick's Cemetery

Location: Mt Savage Md

18. Funeral director: J. R. Durst

Address: Frostburg Md

19. Dec 21 1948 (Date rec'd by registrar) Vernon M. Bennett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 19 1948 at 7:55 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 18 1948 to December 19 1948 and that I last saw her alive on December 19 1948

Immediate cause of death: Intracranial Hemorrhage — DURATION 41 hours

Due to: Generalized arteriosclerosis

Coronary Heart disease

Due to: Generalized Rheumatoid arthritis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE James P. Hallman M.D. M. D. or other

Address: Mt Savage Md. Date signed 12-20-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

1

Within corporate limits DR. WHITWORTH

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

122b (145) 12045

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 DAYS

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CORRIGANSVILLE
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: World War II

3. (a) FULL NAME
MRS. REGINA E. MATTINGLY

3. (b) Social Security Number
172-16-8756

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: DANIEL MATTINGLY

6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): FEBRUARY 28, 1920

8. AGE: Years 28 Months 9 Days 10 If less than one day ... hrs. ... min.

9. Birthplace: Los Angeles [redacted] California
(Town, county, and state)

10. Usual occupation: HOUSE WIFE

11. Industry or business

FATHER
12. Name: THOMAS EMGE
13. Birthplace: PENNSYLVANIA

MOTHER
14. Maiden name: ELLEN SULLIVAN
15. Birthplace: PENNSYLVANIA

18. Informant: MEMORIAL HOSPITAL
Address: MEMORIAL AVE., CITY

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 10, 1948 (month) (day) (year)

Cemetery or crematory: S. S. Peter & Paul

Location: Cumberland, Md.

18. Funeral director: H. Wayne George
Address: Cumberland, Md.

19. Dec 10, 1948 (Date rec'd by registrar) W.R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 8, 1948, at 12:10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Dec 1948 to 8 Dec 1948 and that I last saw he alive on 8 Dec 1948

Immediate cause of death	DURATION
Shock.	
Due to: Intestinal Obstruction	
Due to: Post-op - Adhesions	
Other conditions: 6½ mo. Pregnancy, Labor following Laparotomy (Include pregnancy within 3 months of death)	

Major findings of operation: Intestinal Obstruction, Ileum distal 1/3, Date of op. 6 Dec 48

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Fuller B Whitworth M. D. or other

Address: Cumberland Md. Date signed: 8 Dec 48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

M I T

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

159

12046

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 DAY

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: ~~CUMBERLAND~~ Corrigansville
(If outside city or town limits, write RURAL and give nearest town)

Street No.: BOX 71 ~~[illegible]~~
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME
MATTINGLY ~~BABY BOY~~, WILLIAM ROBERT

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	NEW BORN

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 7, 1948

8. AGE: Years | Months | Days: 1 | If less than one day: hrs. min.

9. Birthplace: MARYLAND Cumberland,
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: MATTINGLY, DANIEL
13. Birthplace: MARYLAND

MOTHER — 14. Maiden name: ~~[illegible]~~ REGINA Emge
15. Birthplace: ~~[illegible]~~

16. Informant: MEMORIAL HOPITAL
Address: MEMORIAL AVE CITY

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec. 10, 1948
(month) (day) (year)
Cemetery or crematory: S. S. Peter & Paul
Location: Cumberland, Md.

18. Funeral director: H. Wayne George
Address: Cumberland, Md.

19. Dec. 10, 1948 (Date rec'd by registrar) W. L. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 8, 1948 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7 Dec 1948 to 8 Dec 1948 and that I last saw h. ~~[illegible]~~ alive on 8 Dec 1948

Immediate cause of death	DURATION
Prematurity 6½ mo	
Due to: Maternal operation	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Fuller B Blackwell M. D. or other

Address: Cumberland Md. Date signed: 8 Dec

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

121147

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

94a

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Home) 114 Lennox Place

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 114 Lennox Place
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: John Robert McDonough

3.(b) Social Security Number: 213-12-9068

4. Sex: male

5. Color or race: white

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Theresa B. Berkenbough McDonough

6.(c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): Sept. 15-1871

8. AGE: Years: 77 Months: 3 Days: 9 If less than one day: hrs. min.

9. Birthplace: Lonaconing Md.
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: Crystal Laundry

FATHER
12. Name: Charles Mc Donough
13. Birthplace: Ireland

MOTHER
14. Maiden name: Suphomia Tate
15. Birthplace: Scotland

16. Informant: wife) Mrs. John R. McDonough

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 27 1948 (month) (day) (year)

Cemetery or crematory: St. Patricks Cemetery

Location: Cumberland Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Dec 26, 1948 (Date rec'd by registrar) W. R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 24 1948 at 11.15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive on Dec. 24 1948

Immediate cause of death: Angina Pectoris — DURATION: 7 years

Due to: coronary sclerosis

Due to:

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Deputy Medical Examiner - Allegany Co.

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or other

Address: Cumberland Md. Date signed: 12-24-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

12048

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

95C

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
Hgw. Buckingham Road. - The Dingle

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 4 Boone St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Albert Walter Middleton

3. (b) Social Security Number
220-10-2596
~~226-10-6681~~

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife: Charlotte Meagher Middleton

6.(c) If alive, give age: 48 years

7. Birth date of deceased (mo., day, yr.): June 23-1892

8. AGE: Years	Months	Days	If less than one day
56	5	17	hrs. min.

9. Birthplace: Carlos Md.
(Town, county, and state)

10. Usual occupation: laborer

11. Industry or business: City of Cumberland Md.

FATHER
12. Name: Alexander Middleton
13. Birthplace: Maryland

MOTHER
14. Maiden name: Matilda Hott
15. Birthplace: Maryland

16. Informant: Mrs. Charlotte Middleton
Address: 4 Boone St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/13/48 (month) (day) (year)

Cemetery or crematory: Allegany Cem.

Location: Frostburg, Md.

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Dec 11 19 48 (Date rec'd by registrar) W. L. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 10 19 48 at 10.45 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19 ... to ... 19 ...

and that I last saw him alive Dead Dec. 10 19 48

Immediate cause of death: Coronary thrombous — DURATION: at once

Due to: coronary sclerosis

Due to:

Other conditions: Cardiac hypertrophy

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

~~Deputy Medical Examiner - Allegany~~

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. M. D. Coroner

Address: Cumberland Md. Date signed: 12-10-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12049

(10) CB

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 days

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 5 days 7 hours 5 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pennsylvania County: Bedford

City or town: Bedford
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R. F. D. 3
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME

Georgia Lee Mock

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 25, 1943

8. AGE: Years	Months	Days	If less than one day
5	10	17	hrs. min.

9. Birthplace: Cumberland, Maryland
(Town, county, and state)

10. Usual occupation: Child.

11. Industry or business

FATHER
12. Name: Robert Mock
13. Birthplace: Centreville, Pennsylvania

MOTHER
14. Maiden name: Wanna Keller
15. Birthplace: W. Va., Marlington

16. Informant: Memorial Hospital

Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 14, 1948 (month) (day) (year)

Cemetery or crematory: P. O. S. of A. Cem.

Location: Centreville, Penna.

18. Funeral director: H. Wayne George

Address: Cumberland, Md.

19. Dec. 13, 1948 (Date rec'd by registrar) W. H. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 12, 1948, at 9:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-7 1948 to 12-12 1948 and that I last saw him alive on 12-12 1948

Immediate cause of death: Diphtheria

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION: 8 days

Major findings of operations:

Date of op.:

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: H. H. Crawford Lee M.D. or other

Address: 12 Spring St. Cumberland Md. Date signed: 12/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 b

12050

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 years

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 223 Fulton St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

MRS. JENNIE VERNIECE MORRIS

3.(b) Social Security Number

217-10-7576

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John T. Morris

6.(c) If alive, give age: 32 years

7. Birth date of deceased (mo., day, yr.): November 13, 1917

8. AGE: Years	Months	Days	If less than one day
31	1	10	hrs. min.

9. Birthplace: Lilly, Cambria, Pa. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER

12. Name: Not known

13. Birthplace

MOTHER

14. Maiden name: Jennie McCready

15. Birthplace: Duncansville, Pa.

16. Informant: John T. Morris

Address: 223 Fulton St. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24, 1948 (month) (day) (year)

Cemetery or crematory: Hill Crest Burial Park

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Dec 24 1948 (Date rec'd by registrar) W. R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: December 23, 1948 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10/15 1948 to 12/23 1948 and that I last saw h[illegible] alive on 12/23 1948

Immediate cause of death: Uremia

Due to: Chronic Nephritis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION: Years

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: 1[illegible] Decatur St. Date signed: 12/23/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits

12051

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

94a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 wk.

Hospital, institution or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1 wks.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Corriganville

(If outside city or town limits, write RURAL and give nearest town)

Street No.: State Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Emory Ernest Morrison

3. (b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Lillian Mullooly

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): June 26 1893

8. AGE: Years: 55 Months: 5 Days: 13 If less than one day: hrs. min.

9. Birthplace: Salisbury, Pa.

(Town, county, and state)

10. Usual occupation: Mechanic

11. Industry or business: State Rd. Com.

FATHER 12. Name: John Morrison

13. Birthplace: Pa.

MOTHER 14. Maiden name: Lydia Price

15. Birthplace: Pa.

16. Informant: Mrs E. E. Morrison

Address: Corriganville Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 13 '48 (month) (day) (year)

Cemetery or crematory: St Patricks Cem.

Location: Mt Savage, Md.

18. Funeral director: Lewis Stem Inc

Address: Cumberland

19. Dec. 11 1948 (Date rec'd by registrar) W. R. Trently, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 9 1948 at 4:06 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1948 to Dec 9 1948 and that I last saw him alive on Dec 9 1948

Immediate cause of death	DURATION
Myocardial Infarction	
Due to: Coronary Thrombosis	1 week
Due to: Arteriosclerosis	20 yr.?
Other conditions: Embolus right popliteal artery	1 week

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.: no

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: no Date of: no

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: no Injured at work?

23. SIGNATURE: Joseph O. Weisenger M.D. or other

Address: 122 Bedford St, Cumberland Date signed: 12/10/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

12985

164 b

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 14

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH — COUNTY: Allegany — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Corrigansville — LENGTH OF STAY (in this place): 10 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS:

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Md. — COUNTY: Allegany
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural) Corrigansville
STREET ADDRESS (If rural, give location):

3. NAME OF DECEASED (Type or Print) — (First): Marcella — (Middle): — (Last): Murray

4. DATE OF DEATH — (Month): Dec. — (Day): 17 — (Year): 19 48

5. SEX: Female

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): married

8. DATE OF BIRTH: April-8-1919

9. AGE last birthday: 29 yrs. — If under 1 year: Months. — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Salisbury Pa.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Murray

14. MOTHER'S MAIDEN NAME: Elsie Fuller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no — (If year, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: George Murray (husband)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

Immediate cause (a) Drowning — ?

Antecedent cause(s) — ?

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE / INJURY (Specify): From all indications suicide — PLACE (Home, farm, factory, street, office, etc.): Jennings Run — (CITY OR TOWN): Corrigansville — (COUNTY): Allegany — (STATE): Md

TIME OF INJURY (Month) (Day) (Year) (Hour): Dec. 17-48-12 about 40 m. — INJURY OCCURRED While at Work ☐ Not While At work ☒

HOW DID INJURY OCCUR? Footprints led to Jennings Run, back of old station.

22. I hereby certify that I ~~attended~~ saw the deceased ~~from~~ Dead Feb. 27, 1949, to ----------, 19--, that I last saw the deceased ~~alive~~ Dead on Feb. 27, 1949, and that death occurred ~~at~~ about 12.40A.m., from the causes and on the date stated above. Dec. 17-1948

SIGNATURE: H.V.Deming M.D. H. V. Deming M.D. — (Degree or title): — ADDRESS: Cumberland Md. — DATE SIGNED: Feb.28-1949

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE: 3/1/49 — NAME OF CEMETERY OR CREMATORY: Reformed Cemetery — LOCATION (City, town, or county) (State): Myersdale Pa.

DATE REC'D BY LOCAL REG.: Feb. 28, 1949 — REGISTRAR'S SIGNATURE: J. Edward Wolfe — Deputy Medical Examiner - Allegany Co.

24. FUNERAL DIRECTOR: Harvey H. Zeigler — ADDRESS: Hyndmav, Pa.

VS. A15

Within corporate limits

Matthews

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131 b

CERTIFICATE OF DEATH

Reg. Dist. No. 12052

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred: 127 Columbia St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland Md (If outside city or town limits, write RURAL and give nearest town)

Street No. 127 Columbia St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Alba James Myers

3.(b) Social Security Number 220-10-0319

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	widowed

6.(b) Name of husband or wife: Mary B. Golia 6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 10, 1882

8. AGE: Years	Months	Days	If less than one day
66	6	1	hrs. ____ min.

9. Birthplace (town, county, and state): Parsons, Tucker Co. W. Va.

10. Usual occupation: Retired Engineer

11. Industry or business: W. Md Railway.

FATHER 12. Name: Benjamin Myers

13. Birthplace: Tucker County, W. Va.

MOTHER 14. Maiden name: Mary Phillips

15. Birthplace: Tucker County, W. Va.

16. Informant: Melvin Myers

Address: 127 Columbia St - Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 14, 1948 (month) (day) (year)

Cemetery or crematory: Zion Memorial Park

Location: Cumberland Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Dec. 13, 1948 (Date rec'd by registrar) W. L. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 11 1948 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec-20 1946 to Dec 11 1948 and that I last saw him alive on Dec-11- 1948

Immediate cause of death: Chronic nephritis

	DURATION
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ____ Injured at work?

23. SIGNATURE: R. Mauskopf M.D. M. D. or other

Address: 49 Greene St Date signed: 12-13-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

12053

95c

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Eckhart

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 years

Hospital, institution, or street address where death occurred: Eckhart, Md. R.F.D. 1 Frostburg

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. No. 1 Box 50

(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

3. (a) FULL NAME: Charles Myers Newman

3. (b) Social Security Number: 217-10-7069

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lora Kelley Newman

6.(c) If alive, give age: 54 years

7. Birth date of deceased (mo., day, yr.): Jan. 7th. 1892

8. AGE: Years: 56 Months: 10 Days: 25 If less than one day: hrs. min.

9. Birthplace: Cumberland Allegany, Md. (Town, county, and state)

10. Usual occupation: Engineering Dept.

11. Industry or business: Celanese Corp.

FATHER 12. Name: Chas. C. Newman

13. Birthplace: Cumberland Md.

MOTHER 14. Maiden name: Nancy Myers

15. Birthplace: McCoole Md.

16. Informant: Mrs. Chas. Newman

Address: R.F.D. No. 1 Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12-14-1948 (month) (day) (year)

Cemetery or crematory: Hill Crest

Location: Cumberland Md.

18. Funeral director: Jacob Walter

Address: Frostburg, Md.

19. 12-13 1948 (Date rec'd by registrar) Mrs. Nancy N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 12 December 1948 at 3 40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from I now 1948 to 12 Dec 1948 and that I last saw him alive on 12 Dec 1948

Immediate cause of death	DURATION
Coronary occlusion due to Thrombosis.	
Due to: Cardiac enlargement	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: None done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John B. Davis M.D. M. D. or other

Address: Frostburg, Md. Date signed 12/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

(I)

Within corporate limits

DR. ROBINSON

EVIDENCE FOR ADDITION IN #21 SHOWN ON:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12054

FILM No. G 110 JAN 25 1949

CERTIFICATE OF DEATH

108

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 DAY

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City, town, or location: CUMBERLAND, ~~MARYLAND~~ Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. # 2 BOX 225 WMS. RD.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME
DEBORAH JANE O'DONNELL

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): JULY 27, 1948

8. AGE: Years: ~~3~~ Months: 4 Days: 24 If less than one day: hrs. min.

9. Birthplace: MARYLAND, Cumberland, Allegany
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: JAMES WILLIAM O'DONNELL
13. Birthplace: MARYLAND Cumberland

MOTHER
14. Maiden name: ROSLINE ESHBAUGH
15. Birthplace: ~~MARYLAND~~ Piedmont, West Virginia

16. Informant: MEMORIAL HOSPITAL
Address: MEMORIAL AVENUE

17. Burial (Burial, cremation, or removal. Which?) Date thereof: December 23, 1948 (month) (day) (year)
Cemetery or crematory: Davis Memorial
Location: Cumberland, Md.

18. Funeral director: James F. Scarpelli
Address: Cumberland, Md.

19. Dec 22 1948 (Date rec'd by registrar) H. R. Strauch, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 21 1948 at 5:15 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/21 1948 to 12/21 1948 and that I last saw h~~er~~ alive on 12/21 1948

Immediate cause of death: Pneumonia, lobar — DURATION

Due to: Right lower lobe was completely consolidated upon autopsy (12/25/48) also

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results: Pneumonia

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thomas Robinson M. D. or other
Address: 19 S. Liberty St. Date signed: 12/22/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Within corporate limits Dr. Durrett

12055

958

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 Days

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 9 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 730 Bedford Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Miss Grace E. Oliver

3.(b) Social Security Number
214-05-6152

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 13, 1886 West Virginia

8. AGE: Years	Months	Days	If less than one day
62	6	12	..... hrs. ..... min.

9. Birthplace: Piedmont, Mineral Co. West Virginia
(Town, county, and state)

10. Usual occupation: House Med Employee

11. Industry or business: Cumberland, Laundry

FATHER
12. Name: George W. Oliver
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Ida Berkly
15. Birthplace: West Virginia

16. Informant: Memorial Hospital
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/28/48 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. Dec. 28 19 48 W. P. Tantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 25 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 18. 1948 to Dec. 25, 1948 and that I last saw her alive on Dec. 25. 1948.

Immediate cause of death	DURATION
Right Cerebral Hemorrhage	1/15/48
Left Hemiplegia	"
Due to: Rheumatic Carditis	7 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Clay R. Durrett M. D. or other

Address: Cumberland Date signed 12/27/48

VS A15 9-45-15

Within corporate limits Dr. Schindler

12056

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

97 CB

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: West Virginia County: Mineral

City or town: Ridgeley
(If outside city or town limits, write RURAL and give nearest town)

Street No. 2 Wabash Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Mrs. Martha Pettet

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Robert Pettet

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): December 6, 1860

8. AGE: Years	Months	Days	If less than one day
88	0	20	..... hrs. ..... min.

9. Birthplace: Bethany West Virginia
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: James McDougan
13. Birthplace: West Virginia

MOTHER
14. Maiden name: Amanda Weaver
15. Birthplace: West Virginia

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/29/48 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland, Md.

18. Funeral director: William H. Kight
Address: Cumberland, Md.

19. Dec. 28, 1948 (Date rec'd by registrar) W. L. Lantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 26, 1948 at 8:40 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1 1948 to Dec. 26 1948
and that I last saw h er alive on Dec 26 1948

Immediate cause of death: Generalized arteriosclerosis — Duration: years

Due to:

Due to:

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE B. M. Schindler M.D. M. D. or other

Address 41 Everett, Cumberland, Md. Date signed Dec 28 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Within corporate limits DR. HODGES

12657

49a

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: MEMORIAL Hospital

How long in hospital or institution? 44 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: WEST VIRGINIA County: HAMPSHIRE

City or town: KIRBY
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

MAE L. POLAND

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: DAILEY L. POLAND

6.(c) If alive, give age: 37 years

7. Birth date of deceased (mo., day, yr.): november 26, 1911

8. AGE: Years	Months	Days	If less than one day
37	—	21	hrs. min.

9. Birthplace: WEST VIRGINIA
(Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER — 12. Name: ~~HIRM~~ Kirsen LEE KLINE
13. Birthplace: W,VA,

MOTHER — 14. Maiden name: MARTHA MICHAEL
15. Birthplace: W.VA.

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 19/48 (month) (day) (year)

Cemetery or crematory: Rockcastle cemetery

Location: Rockcastle w va

18. Funeral director: W.J. McKee

Address: Augusta w va

19. Dec. 19, 1948 (Date rec'd by registrar) W.L. Sauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 17, 1948 at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1948 to Dec. 17 1948 and that I last saw her alive on Dec. 16, 1948

Immediate cause of death: Metastatic Carcinoma — Lymphatic nodes

Due to: Ovarian Ca.

Due to:

Other conditions:

DURATION

(Include pregnancy within 3 months of death)

Major findings of operation: Ovarian tumor removed 1946

Date of op.

Autopsy results: above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W.P. Hodges, M.D.

Address: Cumberland, Md. Date signed 12/18/48

M. D. or other

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-

Outside of Cemetery

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

CERTIFICATE OF DEATH

Reg. Dist. No. 4

12458

1. PLACE OF DEATH:

County: Allegany

City or town: Narrows Park near Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs

Hospital, institution, or street address where death occurred:
Rt #6, Cumberland, Md

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Narrows Park near Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt 6 Cumberland Md
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME George Homer Price

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary Binnix

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Dec 19, ~~1883~~ 1873

8. AGE: Years 74 | Months 11 | Days 19 | If less than one day ..... hrs. ..... min.

9. Birthplace: Everett Bedford Co. Pa
(Town, county, and state)

10. Usual occupation: Foreman - Retired

11. Industry or business: Cumberland Cement & Supply

FATHER
12. Name: John Price
13. Birthplace: Pa.

MOTHER
14. Maiden name: Louanda Eldridge
15. Birthplace: Pa.

16. Informant: Mrs Geo H Price
Address: Rt 1 Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 12 1948 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Dec. 16 1948 W. L. Lantz, M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 8 1948 at 11:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-6 1946 to 12-6 1948

and that I last saw him alive on 12-6 1948

Immediate cause of death: Cirrhosis of Arteriosclerosis — DURATION 2 years

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: James T. Johnson, M.D.
M. D. or other

Address: Cumberland Md Date signed 12-12-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct spelling is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

(I)

Evidence for change of age and birth date shown on: Johnson

FILM No. G 118 DEC 13 1948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

462

12059

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Allegany Hosp.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 111 West Elder St.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MYRTLE MAY PRICE

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: Walter C. Price
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 24, ~~1899~~ 1898

8. AGE: Years	Months	Days	If less than one day
50 M	6	7	..... hrs. ..... min.

9. Birthplace: Cumberland, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Tobias W. Stickley
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Ella Branseone
15. Birthplace: W. Va.

16. Informant: William W. Price
Address: 48 Humbird St., Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 4, 1948 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Dec 3 1948 (Date rec'd by registrar) W. L. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 1, 1948 at 2:00 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Nov 15 1948 to Dec 1 1948 and that I last saw h... alive on Dec 1 1948

Immediate cause of death	DURATION
Obstruction of bowel	1 day
Due to: Neoplasm of rectum and sigmoid colon	6 months
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Obstruction of bowel due to neoplasm of rectum and sigmoid colon Date of op. 12-1-48
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. M. Johnson M.D. M. D. or other
Address: Cumberland Md. Date signed 12-2-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

DR. MEB. OWENS OR DR. ROBINSON

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

161C

12660

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19½ HOURS

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 19½ HOURS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 802 MARYLAND AVENUE
(If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME

BABY BOY ROBISON

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): DECEMBER 22, 1948

8. AGE: Years | Months | Days | If less than one day: 19 hrs. 29 min.

9. Birthplace: CUMBERLAND, ALLEGANY, MARYLAND
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: LESTER ROBISON
13. Birthplace: PENNSYLVANIA

MOTHER — 14. Maiden name: DOLLY S. SHANHOLTZ
15. Birthplace: MARYLAND

16. Informant: MEMORIAL HOSPITAL
Address: MEMORIAL AVE., CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 24, 1948 (month) (day) (year)

Cemetery or crematory: Hillcrest Burial Park

Location: Cumberland, Md.

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Dec. 24, 1948 (Date rec'd by registrar) W. L. Frank M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 22, 1948 at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/22 1948 to 12/22 1948 and that I last saw h alive on 12/22 1948

Immediate cause of death: Diaphragmatic hernia

	DURATION
Due to:	19 hrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 12/24/48

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: MEB Owens M.D. M. D. or other

Address: 173 Va. Date signed: 12/24

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

Within corporate limits

12061

EVIDENCE FOR ADDITION #21 IS ON 107

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

FILM No. G 116 JAN 27 1949

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 1 week

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: North Branch near Cumberland Md. (If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt 4 Cumberland (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Curtis Lee Rohrbaugh

3.(b) Social Security Number: None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Aug 15, 1941

8. AGE: Years 7 Months 4 Days 5 If less than one day ... hrs. ... min.

9. Birthplace (Town, county, and state): Cumberland, Allegany Co., Md

10. Usual occupation: Child

11. Industry or business

FATHER 12. Name: Curtis Rohrbaugh

13. Birthplace: Petersburg W. Va

MOTHER 14. Maiden name: Genevie Arnick

15. Birthplace: Picardy, Md.

16. Informant: Mrs Wm Dirilbiss

Address: Paw Paw W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 22, 1948 (month) (day) (year)

Cemetery or crematory: Hartley Cemetery

Location: Near Oldtown Md.

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Dec 22, 1948 (Date rec'd by registrar) W. L. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 20 1948 at 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 13 1948 to Dec. 20 1948 and that I last saw him alive on Dec. 19 1948

Immediate cause of death: Thrombocytopenia

Acute thrombocytopenic purpura

DURATION

Due to

Due to

Other conditions: Pneumonia - bronchopneumonia?

x ray examination was suspicious of pneumonia (Include pregnancy within 3 months of death) (The child had been exposed to tb) Patch

Major findings of operations: test was pos. The sputum examination was tb negative.

Date of op.

Autopsy results: Autopsy not performed [1/25/49 okay]

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

23. SIGNATURE: Elizabeth Grove, M.D. M. D. or other

Address: La Vale, Md. Date signed 12/29

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

12062

Within corporate limits

Schindler

97

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 yrs.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? ½ day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infant give residence of mother)

State: Md. County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 116 Baca St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Daniel Webster Ryan

3. (b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Tabitha Parsons

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr 2, 1858

8. AGE: Years 90 Months 8 Days 6 If less than one day ..... hrs. ..... min.

9. Birthplace: Randolph Co., W. Va. (Town, county, and state)

10. Usual occupation: Carman

11. Industry or business: W. Md Railroad.

FATHER 12. Name: S. Ryan

13. Birthplace: Beverly W. Va.

MOTHER 14. Maiden name: Unknown

15. Birthplace

16. Informant: Frederick E. Ryan

Address: 137 Arch St - Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 10, 1948 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md.

18. Funeral director: John J. Hafey

Address: Cumberland Md.

19. Dec 10 1948 (Date rec'd by registrar) C. L. Frank M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 8 1948 at 10:30 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 1947 to Dec. 8 1948 and that I last saw him alive on Dec. 7 1948

Immediate cause of death: Generalized arteriosclerosis — DURATION years

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. M. Schweller M.D. Coroner

Address: 4 Gaven St, Cumberland Md. Date signed Dec. 9, 1948

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

DR. JACOBSON

Within corporate limits

12063

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61

Reg. Dist. No. 4

Cue 1454

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? [redacted]

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No. 211 NORTH LEE STREET
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
RUSSELL E. SAUM

3.(b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife: MARGARET STUIBER

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): FEBRUARY 25, 1880

8. AGE: Years	Months	Days	If less than one day
68	9	12	hrs. min.

9. Birthplace: VIRGINIA
(Town, county, and state)

10. Usual occupation: RETIRED SHEET METAL CONTRACTOR

11. Industry or business: FOR HIMSELF

FATHER
12. Name: DANIEL T. SAUM
13. Birthplace: VIRGINIA

MOTHER
14. Maiden name: JENNIE SAUM
15. Birthplace: VIRGINIA

16. Informant: MEMORIAL HOSPITAL
Address: MEMORIAL AVENUE, CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 12/10/48 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Dec. 9 1948 W. R. Trautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 7, 1948 at 7:20PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9 1948 to Dec 7 1948 and that I last saw him alive on Dec 7 1948

Immediate cause of death	DURATION
Uremia	2 wks.
Due to: Cystitis & Pyelitis	?
Due to: Prostatic Enlargement	?
Other conditions: Pneumonia, Uremia	?
Bronchial Pneumonia	?
Left Hydrocele	?

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, ~~public place (where?)~~

Means of injury Injured at work?

23. SIGNATURE: Samuel Jacobson M.D.
M. D. or other

Address: 58 Pershing St. Date signed: 12/8/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Within corporate limits

12064

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 73 yrs 3 – 19

Hospital, institution, or street address where death occurred: 430 Columbia St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 430 Columbia St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Wm. Dr. Schriver

3.(b) Social Security Number None

4. Sex Male **5. Color or race** White **6.(a) Single, married, widowed, or divorced** Single

6.(b) Name of husband or wife —

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Aug 28 1875

8. AGE: Years 73 Months 3 Days 19 If less than one day hrs. min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Anthony J. Schriver

13. Birthplace Germany

MOTHER 14. Maiden name Mary Kerber

15. Birthplace Germany

16. Informant Mrs Emory Wilson

Address Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 20 48 (month) (day) (year)

Cemetery or crematory St Peter & Pauls Cem

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Dec. 20, 1948 (Date rec'd by registrar) W R Bantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1948 at 11 59 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 15 1948 to December 17 1948 and that I last saw h alive on December 17 1948

Immediate cause of death Uremia

Due to Cardiovascular Renal disease

Due to Prostatic enlargement

Other conditions

(Include pregnancy within 3 months of death)

	DURATION
Uremia	
Cardiovascular Renal disease	
Prostatic enlargement	

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George M. Simon M. D. or other

Address 1st Union St. Date signed 12/17/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15 9-45

Within corporate limits Zimmerman

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

186a

12065

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 700 Wills Creek Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Emma Sell

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Sept. 24 1877

8. AGE: Years 71 | Months 2 | Days 17 | If less than one day ... hrs. ... min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

MOTHER FATHER

12. Name Lawrence Sell

13. Birthplace Germany

MOTHER

14. Maiden name Margaret Smith

15. Birthplace Germany

16. Informant Mrs. Alice Spantee

Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 14 1948 (month) (day) (year)

Cemetery or crematory St P.P. Cem

Location Cumberland Md

18. Funeral director Louis Steno Inc.

Address Cumberland Md

19. Dec 14 1948 (Date rec'd by registrar) W.R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 11 1948 at 9:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-26-48 to 12-11-48 and that I last saw her alive on 12-11-48

Immediate cause of death	DURATION
Fractured left hip	11 wk.
Due to: Uremia	3 da.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 9-26-48

Where did injury occur? Cumberland, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury Fall Injured at work?

23. SIGNATURE C. Zimmerman M.D. M. D. or other

Address Cumberland, Md. Date signed 12-13-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Within corporate limits

Weisman

93d

12066

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Rawlings Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. Rt 3 Keyser W. Va.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Harry Shaffer

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 15, 1878

8. AGE:

Years	Months	Days	If less than one day
70	7	25	hrs.

9. Birthplace: Carlisle, Cumberland Co., Pa.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Contracting Bldgs.

FATHER
12. Name: Unknown
13. Birthplace

MOTHER
14. Maiden name
15. Birthplace

18. Informant: Mrs Mary Doss

Address: Cresaptown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 13, 1948 (month) (day) (year)

Cemetery or crematory: Dawson Cemetery

Location: Dawson, Maryland

18. Funeral director: John J. Haley

Address: Cumberland Md.

19. Dec 11, 1948 Wm. L. Krutz M.D. Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH December 10 1948 at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Dec 8 1948 to Dec 10 1948 and that I last saw him alive on Dec 10 1948

Immediate cause of death	DURATION
Splenic Infarction	24 hrs
Due to: Arteriosclerotic Heart Disease	2
Due to: Arteriosclerosis	2
Other conditions	

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Orville G. Weisman M.D. M. D. or other

Address: Cumberland, Md Date signed 12/10/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Eliz Bruns

12067

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

940a

Reg. Dist. No. 5

1. PLACE OF DEATH:

County: Allegany

City or town: Potomac Park near Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Potomac Park near Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rt 6 Cumberland
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Mrs Jessie McKee Shipley

3. (b) Social Security Number: None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Wm Shipley

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): March 24, 1889

8. AGE: Years: 59 Months: 9 Days: 25 If less than one day: hrs. min.

9. Birthplace: Cumberland Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Edward R. Neff
13. Birthplace: Fort Ashby W. Va.

MOTHER
14. Maiden name: Margaret J. McKee
15. Birthplace: Cumberland, Md.

16. Informant: Wm Shipley
Address: Rt 6, Cumberland, Md.

17. Burial, cremation, or removal. Which?
Date thereof: Dec 22 1948 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetery
Location: Cumberland Md.

18. Funeral director: John J. Hofer
Address: Cumberland Md.

19. Dec 22 1948 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 19 1948 at 7:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 17 1948 to Dec. 19 1948 and that I last saw him alive on December 18 1948

Immediate cause of death: Coronary occlusion

Due to: Arteriosclerosis

Due to:

Other conditions: Artrial hypertension

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Elizabeth Bruns, M. D. or other

Address: La Vale, Md. Date signed: 12/21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

Dr Jones

Within corporate limits

12068

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

CERTIFICATE OF DEATH

1454

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two Weeks

Hospital, institution, or street address where death occurred:
Sylvan Retreat

How long in hospital or institution? Two Weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Keifer
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Lewis Charlton Shock

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary Ellen Appold

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): January 13 1874

8. AGE: Years	Months	Days	If less than one day
74	10	28	... hrs. ... min.

9. Birthplace: Baltimore, Maryland.
(Town, county, and state)

10. Usual occupation: Iron and Cement Worker

11. Industry or business: Labor

FATHER
12. Name: Henry Shock
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Alta L Ryan

Address: Keifer, Maryland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 12/14/48 (month) (day) (year)

Cemetery or crematory: Camp Hill Cemetery

Location: Paw Paw, W. Va.

18. Funeral director: W. D. Parks

Address: Berkley Springs, W. Va.

19. Dec 14, 1948 (Date rec'd by registrar) W. R. Hartz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH December 11 1948, at 11 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 24 1948, to Dec. 11 1948 and that I last saw him alive on Dec. 10 1948

Immediate cause of death	DURATION
Myocardial failure	3 hrs.
Due to Generalized arteriosclerosis	2 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE Arthur F. Jones M.D. M. D. or other

Address 110 S. Centre St. Date signed 12-13-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

12069

124 b

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 8

1. PLACE OF DEATH:

County: Allegany

City or town: Klondike (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: None

How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Klondike (If outside city or town limits, write RURAL and give nearest town)

Street No.: None (If rural, give LOCATION)

2.(a) If veteran, name war: No

3.(a) FULL NAME: Walter H. Simpson

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of ~~husband~~ or wife: Bella Brown

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): March 10, 1882

8. AGE: Years: 66 Months: 9 Days: 11 If less than one day: hrs. min.

9. Birthplace: Gilmore, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Coal Mining

11. Industry or business: Osage, W. Va.

FATHER 12. Name: James Simpson

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Hannah Hussy

MOTHER 15. Birthplace: Germany

16. Informant: Miss Elsie J. Hausrath

Address: Klondike Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 23 1948 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md

19. Dec 23 1948 (Date rec'd by registrar) Jennette M. Pool Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 21 Dec 1948 at 3 00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1 Dec 1948 to 21 Dec 1948 and that I last saw him alive on 20 Dec 1948

Immediate cause of death: Uremia

Due to: Chronic nephritis & Chronic Cirrhosis

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.

Autopsy results: None Done

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: John B. Davis M.D. M. D. ~~or other~~

Address: Frostburg, Md. Date signed: 12/22/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

Within corporate limits

12070

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

46 b

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: 9 Laing Ave. Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
9 Laing Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 9 Laing Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
Glenn Semmor Sisk

3.(b) Social Security Number
705-12-7713

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Minnie Valentine Sisk

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): March 31- 1895

8. AGE: Years	Months	Days	If less than one day
53	8	14	hrs. min.

9. Birthplace: Morefield W.Va. Hardy County
(Town, county, and state)

10. Usual occupation: Fireman

11. Industry or business: B&O.R.Ry.

FATHER
12. Name: Robert Sisk
13. Birthplace: Morefield W.Va.

MOTHER
14. Maiden name: Nellie Coffman
15. Birthplace: Morefield W.Va.

16. Informant: Mrs. Minnie V. Sisk
Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 19, 1948 (month) (day) (year)

Cemetery or crematory: Abe Cemetery

Location: Near Ridgeley W.Va.

18. Funeral director: John J. Hafer
Address: Cumberland, Md.

19 Dec. 18, 1948 W.R. Frantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 15 19 48 at 9.25p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw him alive Dec. 15 19 48

Immediate cause of death: Carcinoma of the stomach — Duration: 9 month

Due to:

Due to:

Other conditions: Metastasis

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury: Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H.V. Deming M.D. H.V. Deming M.D.
M. D. or dentist

Address: Cumberland Md. Date signed: 12-16-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

83a

12071

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 9 hrs

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 806 Sephart Dr

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Elmer Joseph Soehner

3. (b) Social Security Number: 705-05-8159

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Rose E. Theatendorf

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Oct. 15, 1893

8. AGE: Years: 55 Months: 1 Days: 20 If less than one day ... hrs. ... min.

9. Birthplace: Dayton, Ohio (Town, county, and state)

10. Usual occupation: Chief Clerk

11. Industry or business: Baltimore & Ohio R.R.

FATHER

12. Name: Oscar Soehner

13. Birthplace: Germany

MOTHER

14. Maiden name: Louisa Heiter

15. Birthplace: Ohio

16. Informant: Mrs. Elmer J. Soehner

Address: Cumberland, Md.

17. Removal & Burial (Burial, cremation, or removal. Which?) Date thereof 12/8/1948 (month) (day) (year)

Cemetery or crematory: Calvary Cemetery

Location: Dayton, Ohio

18. Funeral director: Louis Stein, Inc.

Address: Cumberland, Md.

19. Dec. 6, 1948 (Date rec'd by registrar) W. L. Kauffman, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 5, 1948 at 12:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/15/46 to 12/5/48 and that I last saw him alive on 12/5/48

Immediate cause of death: Cerebral hemorrhage

Due to: Hypertension

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. H. Williams M.D. M. D. or other

Address: Cumberland Md. Date signed 12/5/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-

12072

183

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 8

1. PLACE OF DEATH

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, Institution, or street address where death occurred: St. Mary's Terrace

How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

Street No.: St. Mary's Terrace (If rural, give LOCATION)

2.(a) If veteran, name war: not

3.(a) FULL NAME: Patrick A. Stakem

3.(b) Social Security Number:

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Annie Reid Stakem

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 13, 1876

8. AGE: Years: 72 Months: 7 Days: 19 If less than one day: hrs. min.

9. Birthplace (Town, county, and state): Lonaconing, Allegany Co., Md

10. Usual occupation: Carpentering

11. Industry or business: Different Lonaconing places

FATHER 12. Name: Patrick Stakem

FATHER 13. Birthplace: Ireland

MOTHER 14. Maiden name: Esther Cavanaugh

MOTHER 15. Birthplace: unknown

16. Informant: Mrs. Annie Reid Stakem

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 6, 1948 (month) (day) (year)

Cemetery or crematory: St. Mary's Cemetery

Location: Lonaconing, Md

18. Funeral director: M. Eichhorn

Address: Lonaconing, Md

19. Dec 6 1948 (Date rec'd by registrar) Jannette M. Boal Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 2 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19

and that I last saw him Dead Dec 3 1948

Immediate cause of death: Drowning

DURATION: a few minutes

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accidental Date of: Dec 2/48

Where did injury occur? Lonaconing (City or town) Allegany (County) Md (State)

Injured at home, farm, industry, public place (where?) St. Mary's Terrace

Means of injury: Fell in water filled ditch Injured at work? No

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H. V. Deming M.D. M. D. or other

Address: Cumberland, Md Date signed: Dec 4/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

M

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M

12073

170C

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. ~~20~~ 14

1. PLACE OF DEATH:

County: Allegany

City or town: Route 36 Hgw. Corrigansville Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death: a few minutes

Hospital, institution, or street address where death occurred:
a few minutes

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 11 Washington St.
(If rural, give LOCATION)

2.(a) If veteran, name war: W. War 1

3. (a) FULL NAME: William Stewart

3. (b) Social Security Number: 220-10-2128

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of decessed (mo., day, yr.): June 22 1881

8. AGE:

Years	Months	Days	If less than one day
67	5	15	hrs. min.

9. Birthplace: Eckhart Mines Md.
(Town, county, and state)

10. Usual occupation: Deputy clerk

11. Industry or business: Magistrates Court.

FATHER
12. Name: John R. Stewart
13. Birthplace: Scotland

MOTHER
14. Maiden name: Mary R. Watson
15. Birthplace: Scotland

16. Informant: John Stewart,
Address: Eckhart, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 10 '48 (month) (day) (year)

Cemetery or crematory: Eckhart Cemetery,

Location: Eckhart, Md.

18. Funeral director: J. R. Durst,
Address: Frostburg, Md.

19. Dec 9 (Date rec'd by registrar) 19 48 Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 7 19 48 at 4.10p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on Dead Dec. 7 19 48

Immediate cause of death	DURATION
Broken neck	at
Fracture of 4th. cervical	once
veterbrae	
Due to: an automobile accident.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Auto. accident Date of 12-7-48

Where did injury occur? Hgw. Roure 36 (City or town) Corrigansville (County) Allegany (State) Md.

Injured at home, farm, industry, public place (where?): Hgw. Route 36

Means of injury: Auto & Truck Collision Injured at work? no

Deputy Medical Examiner - Allegany

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. M. D. or other

Address: Cumberland Md. Date signed: 12-8-48

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

12074

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
603 Patterson Ave.,

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland,
(If outside city or town limits, write RURAL and give nearest town)

Street No. 603 Patterson Ave.,
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
ANNA CRESAP STOTLER

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Floyd L. Stotler

Deceased 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. ? 1862

8. AGE: Years	Months	Days	If less than one day
86	?	?	hrs. min.

9. Birthplace: Near Keyser, W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Charles Cresap
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Barbara Weirs
15. Birthplace: W. Va.

16. Informant: Mr. Floyd L. Stotler
Address: Colfax, Washington

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 14, 1948 (month) (day) (year)

Cemetery or crematory: Rose Hill

Location: Cumberland, Maryland

18. Funeral director: H. Wayne George
Address: Cumberland, Md.

19. Dec. 13, 1948 (Date rec'd by registrar) W. R. Smith M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11, 1948, at 10:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov-3- 1948, to Dec-11 1948 and that I last saw her alive on Dec-11- 1948

Immediate cause of death: Chronic Nephritis (Senile)

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. M. Lewis M.D.
M. D. or other

Address: 44 Greene St. Date signed: 12/13/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170C

12075

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 19 hours

Hospital, institution, or street address where death occurred:
Miners Hospital

How long in hospital or institution? 19 hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 204 McCulloh St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
Larry Michael Stott

3. (b) Social Security Number
none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.) Dec.2-1941

8. AGE: Years 7 | Months | Days 12 | If less than one day ... hrs. ... min.

8. Birthplace: Frostburg Md.
(Town, county, and state)

10. Usual occupation: student

11. Industry or business

FATHER
12. Name: Godfery D.Stott
13. Birthplace: Frostburg Md.

MOTHER
14. Maiden name: Dorothy M.McKenzie
15. Birthplace: near Grantsville Md.

16. Informant: Godfery D.Stott
Address: Frostburg Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Dec. 17 '48
(month) (day) (year)

Cemetery or crematory: St. Anne's Cemetery,

Location: Avilton, Garrett Cty., Md.

18. Funeral director: J. R. Durst,
Address: Frostburg, Md.

19. 12-16 19 48 Mrs. Nancy H. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec.14 19 48 at 1125A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...
and that I last saw him Dead Dec.14 19 48

Immediate cause of death: Intracranial hemorrhage — DURATION: 19 hrs.

Due to: a fracture of the skull

Due to: Hit by an automobile

Other conditions: Fracture of ~~left~~ RIGHT femur.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Auto accident Date of 12.13-48

Where did injury occur? Frostburg (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?) Grant St.

Means of injury: Hit by an Auto. Injured at work? no

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H.V.Deming M.D. H.V.Deming M.D.
M. D. or Coroner

Address: Cumberland Md. Date signed: 12-14-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131b

12076

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany county

City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 years

Hospital, Institution, or street address where death occurred:
The Dingle, Cumberland, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. The Dingle
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
Mrs. Beatrice Minerva Holmes Syckes

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife S. Lua Syckes, Sr.

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 19, 1880

8. AGE: Years	Months	Days	If less than one day
68	7	0	hrs. min.

9. Birthplace Pittsburgh, Pa.
(Town, county, and state)

10. Usual occupation Music Teacher

11. Industry or business

FATHER
12. Name Josiah Holmes,
13. Birthplace England

MOTHER
14. Maiden name Sara Ann (Wilton) Holmes
15. Birthplace Haysville, Pennsylvania

16. Informant Wilton Holmes Syckes

Address 901 Braddock Road, Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 22, 1948 (month) (day) (year)

Cemetery or crematory Rose Hill Mausoleum

Location Rose Hill Mausoleum, Cumberland

18. Funeral director John E Warford

Address 125 S Liberty St

19. Dec. 22, 1948 W. H. Stautz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 19th 1948 at 1030P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 29th 1948 to Dec 19 1948 and that I last saw her alive on Dec 19th 1948

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 1/2 hrs
Due to: Hypertension &	20 and years
Due to: Chronic nephritis	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R L Owens M.D.
M. D. or other

Address Pennsylvania Ave Date signed 12-21-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12079

124 b

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all his life

Hospital, Institution, or street address where death occurred: 21 Bowery St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg (If outside city or town limits, write RURAL and give nearest town)

Street No. 21 Bowery St. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Richard H. Thomas

3. (b) Social Security Number: 214-05-9815

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Myrtle Thomas 6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): February 5 1908

8. AGE: Years 40 Months 10 Days 0 If less than one day hrs. min.

9. Birthplace: Lonaconing Allegany Md. (Town, county, and state)

10. Usual occupation: Truck driver

11. Industry or business: Corporation - Frostburg

FATHER 12. Name: William Thomas

13. Birthplace: Maryland

MOTHER 14. Maiden name: Minnie Hitchison

15. Birthplace: Maryland

16. Informant: Anna Thomas

Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 8 1948 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md.

18. Funeral director: J. R. Durst

Address: Frostburg Md

19. 12-8 1948 (Date rec'd by registrar) Maurice N. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 6 1948 at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1948 to Dec 6 1948 and that I last saw him alive on Dec 5 1948

Immediate cause of death: Cirrhosis of Liver — DURATION 12 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE: W. D. McLane M. D.

Address: Frostburg Md Date signed 12-7-48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

93d

12077

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: rural near McCoole
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:
R#3, Keyser, W. Va.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: rural near McCoole
(If outside city or town limits, write RURAL and give nearest town)

Street No. R#3, Keyser, W. Va.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME
(Mrs) Emma Viola Thompson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Charles Edward Thompson

Died Apr. 24, 1927 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 11, 1872

8. AGE: Years	Months	Days	If less than one day
76	8	0	..... hrs. ..... min.

9. Birthplace: Wheeling, W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Samuel Smith
13. Birthplace: Unknown

MOTHER
14. Maiden name: Sarah Dean
15. Birthplace: Unknown

16. Informant: Mrs. Estella Mae Likens

Address: 2415 20th St. N.E. Canton 5, Ohio

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 14, 1948 (month) (day) (year)

Cemetery or crematory: Queenspoint

Location: Keyser, W. Va.

18. Funeral director: Rogers Funeral Home

Address: Keyser, W. Va.

19. Dec. 14 19 48 [illegible] Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11th. 19 48, at 3.20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 10 19 48, to Dec 11 19 48 and that I last saw her alive on Dec 11, 19 48

	DURATION
Immediate cause of death: Coronary occlusion	1 3 hrs
Cardio vascular disease	3 years
Due to: Arteriosclerosis	10 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: E. A. Courrier M.D.
M. D. or other

Address: Keyser, W. Va. Date signed: 12-13-48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

Within corporate limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

13/a

12078

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs

Hospital institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 1 wk.

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 115 Frederick St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Isaac Turnbull

3.(b) Social Security Number None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Agnes Reynolds

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): June 5 1867

8. AGE: Years 81 Months 6 Days 11 If less than one day ... hrs. ... min.

9. Birthplace: Glasgow Scotland (Town, county, and state)

10. Usual occupation: Fireman - Retired

11. Industry or business: W. Md Ry.

MOTHER FATHER

12. Name: Robert Turnbull

13. Birthplace: Scotland

14. Maiden name: Margaret Dobson

15. Birthplace: Scotland

16. Informant: James C Turnbull

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 19 48 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. Dec 18, 1948 (Date rec'd by registrar) W. L. Fautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec 16th 1948 at 10 25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 26 1947 to Dec 16 1948 (Saw) and that I last saw h. alive on December 16 1948

Immediate cause of death	DURATION
Heart Failure	10 hrs.
Due to Arteriosclerotic and Hypertensive Cardiovascular	10 yr.?
Due to Renal disease	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: no

Date of op.

Autopsy results: no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lavelle G. Weaver MD M. D. or other

Address: Cumberland, Md Date signed 12/17/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

Outside City limits

12680

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: route 220 (highway) near Amcelle
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~about 2 hours~~

Hospital, institution, or street address where death occurred:
Mc. Mullen Hwy near Celanese Corp. of Am.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cresaptown
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: World War 2

3. (a) FULL NAME: Milton George Urner Vanmeter

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 21-1923

8. AGE:

Years	Months	Days	If less than one day
25	3	13	hrs. min.

9. Birthplace: Cresaptown Md.
(Town, county, and state)

10. Usual occupation: Merchant

11. Industry or business: Grocery store

FATHER
12. Name: Milton George Vanmeter
13. Birthplace: Cresaptown Md.

MOTHER
14. Maiden name: Clarabelle Brotemarkle
15. Birthplace: Cumberland Md.

16. Informant: M. G. Vanmeter

Address: Cresaptown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 5th 1948 (month) (day) (year)

Cemetery or crematory: Hillcrest Bur. Park

Location: Cumberland, Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland, Md.

19. Dec 4 1948 W. R. Trautz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 3 1948 at 2.40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on Dead Dec. 3 1948

Immediate cause of death: Shock & exposure — Duration: at once

Due to: Automobile accident

Due to:

Other conditions: Abrasions & contusions of hands & forehead, laceration of scalp back of right ear.
(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Auto. accident Date of: Dec. 3-48

Where did injury occur? near Cumberland (City or town) Allegany (County) Md. (State)

Injured at home, farm, industry, public place (where?): Route 220 Hgw.

Means of injury: Auto. out of control Injured at work? no

Deputy Medical Examiner - Allegany Co

23. SIGNATURE: H. V. Deming M.D. H. V. Deming M.D. M. D. or Coroner

Address: Cumberland Md. Date signed: 12-3-48

VS A15 9-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Within corporate limits

DR.W.F.WMS

12081

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~3 DAYS~~ 70 yrs.

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 3 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: MARYLAND County: ALLEGANY

City or town: CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 30 N. LIBERTY ST. (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: ROSELLA R WADSWORTH

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: WILLIAM R. WADSWORTH

6.(c) If alive, give age: 74 years

7. Birth date of deceased (mo., day, yr.): SEPT. 3, 1876

8. AGE: Years 72 | Months 3 | Days 17 | If less than one day ... hrs. ... min.

9. Birthplace: PENN. (Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business

FATHER — 12. Name: DAVID KOUGH

13. Birthplace: PENN

MOTHER — 14. Maiden name: ~~HENRY ELLAMAE~~ Ellen R. Henry

15. Birthplace: PENN.

16. Informant: MEMORIAL HOSPITAL

Address: MEMORIAL AVE. CUMB. MD

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec 22 48 (month) (day) (year)

Cemetery or crematory: Odd Fellows Cem.

Location: Rockwood Pa.

18. Funeral director: Louis Stein Inc

Address: Cumberland.

19. Dec 22 1948 (Date rec'd by registrar) W.R. Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DEC. 20, 1948 19 ... at 5:17 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 12/3/48 19 to 12/20 19 48 and that I last saw h alive on 12-19-48 19 48

Immediate cause of death: Chronic Myocarditis

Due to: Degenerative Arteriosclerosis

Due to:

Other conditions:

DURATION

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Wm. F. Williams M. D. or other

Address: Cumberland Date signed 12/20/48

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

Mr. Stone

Within corporate limits

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

932

12082

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: ~~[illegible]~~ Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? ~~about 15 minutes~~ 40 yrs

Hospital, Institution, or street address where death occurred:
133 Va. Ave.

How long in hospital or institution? 15 min.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 137 Maple St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME
Julius Vandivier Wagner

3. (b) Social Security Number
721-16-987

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife: Anna Reuschel Wagner

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Jan. 30- 1883

8. AGE:

Years	Months	Days	If less than one day
65	10	12	hrs. min.

9. Birthplace: Fort Ashby W.Va.
(Town, county, and state)

10. Usual occupation: Carman

11. Industry or business: B&O.R.Ry.

FATHER
12. Name: William A. Wagner
13. Birthplace: Greenspring W.Va.

MOTHER
14. Maiden name: Etta Ward
15. Birthplace: Greenspring W.Va.

16. Informant: Anna R Wagner
Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec 15 48 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem.
Location: Cumberland

18. Funeral director: Louis Stein Inc.
Address: Cumberland

19. Dec. 14, 1948 W.L. Frantz M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 12 19 48 at 2.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ... to ... 19 ...
and that I last saw him alive Dead Dec. 12 1948

Immediate cause of death	DURATION
Coronary occlusion	at once
Due to: coronary sclerosis	
Due to:	
Other conditions: Chronic myocarditis	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

Deputy Medical Examiner - Allegany Co

23. SIGNATURE H.V. Deming M.D. H.V. Deming M.D.
Medical examiner or other

Address: Cumberland Md. Date signed 12-13-48

DR. W. F. WILLIAMS

Within corporate limits

12083

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

46 b CD

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: ALLEGANY

City or town: CUMBERLAND

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 26 DAYS

Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 26 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: PENNSYLVANIA County:

City or town: LITTLE'S TOWN, PA.

(If outside city or town limits, write RURAL and give nearest town)

Street No. RD. #2

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME ROBERT M. WALTON

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): FEBRUARY 26, 1893

8. AGE: Years	Months	Days	If less than one day
55	9	14	hrs. min.

9. Birthplace: MARYLAND Cumberland (Town, county, and state)

10. Usual occupation: Salesman

11. Industry or business: Howe Fire Equipment Co.

FATHER — 12. Name: EDWARD WALTON

13. Birthplace: MARYLAND Cumberland,

MOTHER — 14. Maiden name: EMMA J. FREDICKS

15. Birthplace: MARYLAND Cumberland,

16. Informant: MEMORIAL HOSPITAL

Address: MEMORIAL AVE., CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Dec. 13, 1948 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland, Md.

18. Funeral director: H. Wayne George

Address: Cumberland, Md.

19. Dec 11, 1948 (Date rec'd by registrar) W.R. Trautz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: DECEMBER 10, 1948 at 8:40 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 10-23-1948 to 12-10-1948 and that I last saw him alive on 12-10-1948

Immediate cause of death	DURATION
Carcinoma of stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.:

Autopsy results: See above cause of death

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 12/11/48.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

Within corporate limits

M

MARGIN RESERVED FOR BINDING

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

12084

61

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 2 hours.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 186 N. Center St.
(If rural, give LOCATION)

2.(a) If veteran, name war: 1

3. (a) FULL NAME

Joseph Willard Weaver

3. (b) Social Security Number

>

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mary O'neal Weaver

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): Jan. 13-1880

8. AGE: Years	Months	Days	If less than one day
68	10	24	____ hrs. ____ min.

9. Birthplace: Burnsville W. Va. Logan Co.
(Town, county, and state)

10. Usual occupation: Retired R. Ry. Engineer

11. Industry or business: W. Md. R. Ry.

FATHER
12. Name: Blackburn Weaver
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Nancy E. ——
15. Birthplace: W. Va.

16. Informant: Mrs Jos. W. Weaver
Address: Cumberland

17. Burial (Burial, cremation, or removal Which?) Date thereof: Dec 10 48 (month) (day) (year)
Cemetery or crematory: St Patricks Cem.
Location: Cumberland

18. Funeral director: Louis Stein Inc.
Address: Cumberland

19 Dec 9, 1948 (Date rec'd by registrar) W. L. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 7 19 48 at 7.55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 7 19 48, to Dec. 7 19 48 and that I last saw him alive on Dec. 7 19 48

Immediate cause of death	DURATION
Diabetes mellitus	8 yrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ____ Date of op. ____

Autopsy results ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

Deputy Medical Examiner - Allegany

23. SIGNATURE H. V. Deming M.D. H. V. Deming M.D. M. D. or other

Address: Cumberland Md. Date signed 12-8-48